Université de Montréal

The recovery perspective in Assertive Community Treatment: how is it done and what does it mean to services users and service providers?

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Résumé

La présente étude s'intéresse à l'approche du rétablissement dans les milieux de pratique en santé mentale au Québec. Par le biais d'une analyse des actions et des interactions quotidiennes des divers acteurs impliqués au sein d'une équipe d'intervention communautaire de Suivi Intensif dans le Milieu (SIM), la recherche menée permet de comprendre une des applications des politiques québécoises en santé mentale. En mettant en contexte les actuelles politiques de santé mentale, les deux premiers chapitres illustrent certains des paradoxes, des défis et des préoccupations liés aux diverses conditions de pratique dans le champ de la santé mentale. Plus spécifiquement, il présente le développement du Suivi Intensif dans le Milieu (SIM) et la pratique axée sur le rétablissement, ainsi que leur légitimation, au regard des approches d'intervention préconisées en santé mentale au Québec et des contextes organisationnels dans lesquelles elles sont mises en œuvre. Le troisième chapitre expose le cadre théorico-conceptuel de l'étude, lequel s'ancre dans la perspective critique constructiviste, et s'inspire de la « pratique critique » (*critical practice*), de l'ethnométhodologie et des *framing theory* pour l'analyse des données empiriques. Le cadre méthodologique qui circonscrit la recherche, et notamment l'approche par observation-participante, qui s'est étalée sur une période de 7 mois d'immersion au sein d'une équipe SIM à Montréal, fait l'objet du quatrième chapitre. De façon cohérente avec la méthode ethnographique, le cinquième chapitre fournit une description en profondeur du contexte de pratique, de l'équipe d'intervention choisie et étudiée ainsi que des acteurs qui la composent. À l'intersection des paradigmes de la médicine traditionnelle, du rétablissement et des perspectives managériales influençant le champ de la santé mentale, le sixième chapitre met en perspective les opportunités et les défis qui émanent des actions et des interactions de l'équipe SIM observée. Quant au septième chapitre, il résume les expériences quotidiennes des personnes utilisatrices et des intervenants, par le biais des observations consignées à propos de leurs rôles professionnels et sociaux, de leurs activités ainsi que de leurs échanges et interactions. En s'appuyant sur des exemples de cas, des citations détaillées ainsi que sur les observations menées, chacun de ces trois chapitres de résultats explicitent les tenants et aboutissants des actions et des interactions quotidiennes, ainsi que l'influence du contexte organisationnel, des schémas de pratique et des discours dominants en santé mentale. Le dernier chapitre se penche sur les modalités et les dynamiques d'interaction des intervenants et des utilisateurs de services, au regard du contexte local et urbain de pratique. En focalisant ainsi sur les contenus relationnels des échanges entre les acteurs, cette discussion offre une analyse approfondie des modes de (re)production de la folie, et de leur mobilisation dans le champ de la santé mentale au Québec.

Mots clés: rétablissement, santé mentale, suivi intensif dans le milieu, pratiques

Abstract

The present study proposes an exploration of the daily actions and interactions amongst various actors in an Assertive Community Treatment psychiatric team as a way to understand the practical operationalization of mental health policy orientations such as recovery. Chapters one and two illustrate some of the paradoxes, challenges and concerns related to the various conditions of mental health practice in an intensive community mental health team in the context of current mental health policies. In particular, the development and ensuing legitimacy of both Assertive Community Treatment and recovery-oriented practice in Québec as well as the current organizational contexts and intervention approaches are detailed. The third chapter outlines the framework for the study, which is based on a critical constructionist perspective and draws upon critical practice, ethnomethodology, and framing theories for data analysis. The fourth chapter summarizes the ethnographic methodology undertaken for data collection. This transpired during 7 months of immersive participant observation with an urban Montréal team of mental health professionals and service users. Consistent with ethnographic methods, the fifth chapter presents a "thick description" of the team, the various actors, and the context of practice. The sixth chapter illustrates the opportunities and challenges of acting and interacting in an intensive community mental health team at the intersection of traditional medical paradigms, and recent policy paradigms, such as recovery and managerialism. The seventh chapter illustrates everyday experiences of service providers and service users as seen through their activities and conversations as well as the actualization of their roles. Drawing on case examples and detailed citations and observations each of the three results chapters explains how daily actions and interactions are accomplished and influenced by context, practice routines, and conversations. The eighth chapter reflects on the ways service providers and service users in a local, urban Montréal ACT team interact in their current context. This final discussion chapter provides a deeper reflection as to how and why relationships with each other, and with madness, are produced and mobilized.

Key words: recovery, mental health, Assertive Community Treatment, practice

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Abbreviations

ACT	Assertive Community Treatment
CASW	Canadian Association of Social Workers
CNESM	Centre National d'excellence en santé mentale
CTESQ	Conseil d'évaluation des technologies de la santé du Québec
CURA	(International) Community – University Research Alliance – mental health and citizenship
EBP	Evidence based practice
IFSW	International Federation of Social Workers
IIP	Individual Intervention Plan
IMR	Illness Management and Recovery
IPS	Individual Placement and Support
MHAP	Mental Health Action Plan
MHCC	Mental Health Commission of Canada
MSSS	Ministère de la santé et des services sociaux
NGO	Non governmental organization
NPM	New Public Management
PRISM	Projet de reaffiliation en itinérance et santé mentale
OBM	Old Brewery Mission
RACOR	Réseau alternative et communautaire des organismes en santé mentale d l'Ile de Montréal
RRASMQ	Regroupement des ressources alternatives en santé mentale du Québec
SAMHSA	Substance Abuse and Mental Health Services Administration
TMACT	Tool for measurement of assertive community treatment
WRAP	Wellness Recovery Action Plans

Acknowledgments

This journey, in which I sought to develop and provide a better understanding of community mental health design and delivery and a better understanding of the experience of this practice for both service users and service providers, was inseparable from the journey of my personal life.

During the last 6 years not only did I have the privilege of meeting with and working with the participants of this project, but I also had the opportunity to enrich my exposure and understanding of mental health practice, service design and delivery, and most profoundly my understanding of the lived experience of mental health difficulties. This was accomplished in part through my participation in the International *Alliance de recherche universités-communautés: Santé mentale et citoyenneté,* in my work on various research projects, and through the learnings and interactions I had at various national and international conferences. I thank all of the friends, co-workers, research participants, citizens, people with lived experience, and acquaintances that fundamentally shaped this journey including Pierre-Luc, Lisa, Thais, Paula, Celine, Isabelle R., Marie-Laurence, Nicholas, Isabelle M. and Marie-Joelle. A particular thank you goes out to Lourdes Rodriguez whose direction and support served as guideposts in this journey.

However, the most impactful experiences of the last 6 years have occurred outside of the research and academic setting. Foremost, are the continuous bubbles of laughter from my 3 children, my amazement at their personal growth, their wonder in the natural world and in others, their innocent yet pointed understanding of social justice and fundamental human rights, their interest in my research, and their encouragement to finish the PhD have all contributed to the uniqueness of this journey and to my epistemological understandings of what we know and how we know it. Olivier, Charlotte, and Simone you have unwittingly been my anchors in this journey.

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Introduction

> " Justice must always question itself,
> just as society can only exist by means
> of the work it does on itself and on its
> institutions"
> - Michel Foucault

The concept of recovery, complex and heterogeneous, has become the dominant organizing principle for public mental health services in many countries in the last two decades. It is often referred to as a radical philosophy within traditional psychiatry, proposing a paradigm shift away from a stigmatizing, disease-based model of care.[1] This approach also proposes an essential change in the social position of people living with or having lived with mental health issues[2]. The recovery approach resulted in important changes in the strategic direction and in the practice guidelines of mental health delivery systems. There have been many attempts at conceptualizing, mapping, and defining recovery-oriented practice[3] whose values include process-oriented and person-centered services, a move away from the disease model of care, service user involvement, shared decision-making, empowerment, hope, social justice, and human rights. Some core principles[4] of recovery-oriented care have been suggested in the literature, including that of community focused care.[5] As explained by Stein (1989) in Davidson et al. (2009), care that is provided outside of hospital settings is

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[1] It is also a highly contested concept and will be discussed in detail in Chapter 2

[2] "At the core we are all the same. There is no us and them" (Mental Health Commission of Canada, 2009, p.9)

[3] see Chen, Krupa, Lysaght, McCay & Piat, 2013; Davidson, Harding & Spaniol, 2006; Davidson, Tondora, Lawless, O'Connell & Rowe, 2009; Mental Health Commission of Canada, 2009

[4] Values being guidelines for practice, whilst principles are based on scientifically derived knowledge or well-examined experience as well as values.

[5] See Anthony, 2000; Chamberlin, 1998; Davidson et al., 2009; Deegan, 1997; Farkas, 1996; Jacobson and Greenley, 2001; Jacobson and Curtis, 2000; O'Connell, Tondora, Croog, Evans, & Davidson, 2005

community *based* care, not to be confused with the more complex community *focused* care which shares many recovery values such as: promoting the development of citizenship roles and connection with social roles in the community; finding meaning and purpose in life; working to fight stigma and increase access to a variety of resources, and developing a positive culture of healing (Davidson et al., 2009).

More recently, recovery is being discussed in tandem with citizenship rights, responsibilities, and social roles (Davidson, 2006; Government of Québec, 2015; Rodriguez et al, 2006; Rowe & Pelletier, 2012). My research is supported, inspired, and nourished by the multiple exchanges and interactions I had as a participant and member of the International Community University Research Alliance (CURA) for Mental Health and Citizenship (Rodriguez and Onocko, 2015) which was engaged in an international effort to renew practices and initiate social transformation so that people living with severe mental health issues could have the space and place to exercise their rights and live a life of quality in their community of choice. This is important for any discussion or research in this field because people living with mental health problems are particularly affected by structural and symbolic inequalities (Poirel, Weiss, Khoury & Clément, 2015). These inequalities often result in, and maintain, their situation of marginalization and social exclusion. Coupled with the negative effects of stigmatization, this social exclusion, understood as both a situation and an interactional process (Castel, 1991), is too often a barrier to participation and exercising full citizenship rights.

Mental health recovery is an experience whose conceptualization is anchored in the narratives of mental health service users. This concept, or experience, is present in the narratives of mental health users in North America as early as the 1930's (Onken, Dumant, Ridgway, Dornan, & Ralph, 2002, p.7). Later, in the 1960's, the civil rights movements of historically oppressed peoples provided fertile ground for the anti-psychiatry and psychiatric survivor movements to promote, discuss, and research practices that empower service users and restore their civil rights by decreasing stigmatization, allowing for subjective constructions of reality, reducing the impact of labeling and inadequate diagnostic criteria, and creating room for social change and social inclusion (Chamberlin, 1977; Deegan, 1988). This movement argued that mental health problems are not caused by a brain illness and that a cure is not the paramount objective. One of the political implications of this movement suggests that responding to mental health problems should not be the sole responsibility of the medical profession (McCulloch, Ryrie, Williamson, & St-John, 2005).

In Québec, the term 'recovery'[6] echoed the practices and approaches that had been previously developed by the community and alternative resources. A long-standing social and political movement involving people living with or having lived with mental health problems, community organizations, and consumer rights activists as well as academic literature in Québec, contributed significantly to the acknowledgement for a need to transform the mental health service system. Later, in the 1980's, longitudinal studies demonstrated that many mental health service users obtained their goals of autonomy and recovery and no longer needed to be 'in the system' (Harding, Brooks, Ashikaga, Strauss and Breier, 1987). The leading voices discussing recovery in the literature in the 1990's were those of survivors (Deegan, 1988, 1997; Chamberlin, 1997) and authors from major psychosocial rehabilitation centres in the United States (Anthony, 1993) who were developing empowerment models of

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[6] The term recovery has been translated to *rétablissement* although francophones will often use *rétablissement* and recovery interchangeably.

mental health care and researching the concept of recovery. The recovery approach from a service user perspective speaks directly about equality, integration, and inclusion (Chamberlin, 1997; Deegan, 1988, 1997; Mead & Copeland, 2000). Initially, accounts of recovery were used to build practice models for use in psychosocial rehabilitation services (Farkas and Vallée, 1996).

Thus, the recovery orientation has its source in different voices, advocacy efforts from the psychiatric survivor movement, the empirical findings of longitudinal studies and the shift in scope of psychiatric rehabilitation services, which concurrently influenced mental health policy makers internationally. With the release of the 2005-2010 Mental Health Action Plan (MHAP), Québec is one of the first non-Anglo-Saxon societies to adopt an official recovery orientation in mental health policy. It employed a discourse of service user participation and community follow up in its explication of recovery-oriented practice. The most recent 2015-2020 Mental Health Action Plan (MHAP) in Québec represents a shift in lexicon from participation to full citizenship as a way to understand and accomplish recovery-oriented care and services. Full citizenship is articulated as the maintenance of desired social roles (Government of Québec, 2015, p.13) wherein mental health recovery might be supported through awareness raising, service user participation in planning and organizing services, and social integration through education, employment, and housing. It is worthwhile to note that while both policies adopt progressive language regarding the conceptualization of mental health problems, they simultaneously adopt managerial language regarding measuring and evaluating the efficiency and performance of the mental health care system. Are these discourses compatible? How do these discourses coexist as they are translated into mental health programs and interventions?

Community mental health programs, or community support models, were flagged for development in the first MHAP (2005-2010) and referred to as foundational to the success of the policy. The expansion of community mental health programs implies a reconsideration of the relationship between service users, service providers, and the community; of the understanding of mental health difficulties and social suffering; and of the place and space occupied in the clinic and in society of people living with mental health problems. Community support models are associated with a variety of practices ranging from personal development to basic functioning (Bond, 1991; Phillips et al., 2001; Teague et al., 1998) and make use of different perspectives ranging from a strengths-based approach to a pharmacological approach (Rodriguez, 2011). Assertive Community Treatment (ACT) programs are specialized community mental health programs with a focus on hospital avoidance and symptom management through pharmacological psychiatric treatment and intensive contact with service providers in the community. They have been prioritized and have seen a prolific expansion in Québec public mental health services since 2009. The Québec government described a contemporary ACT program as:

> *"un service spécialisé, généralement offert par les hôpitaux psychiatriques ou par les départements de psychiatrie des hôpitaux de soins généraux. Ce service est l'ultime recours pour maintenir les personnes atteintes de troubles mentaux graves dans leur milieu de vie. Par le biais de contacts soutenus et d'un encadrement rigoureux, il permet d'éviter les hospitalisations prolongées et de diminuer le fardeau des aidants naturels" (Government of Québec, p. 7, 2009).*

In other words, ACT programs were established in North America, and more recently in Québec, in order to replace the asylum model of care in which people with severe mental illnesses were housed away from society for long periods of time. The establishment of ACT teams in North America followed a larger scale healthcare transformation that began in the early 1980's. This transformation, influenced in part by a neoliberal ideology, an economic goal of zero deficit, and the emergence of New Public Management (NPM)[7] as an administrative approach in the public sector, aimed at reducing the economic costs of health care service delivery. This resulted in changes in the way public health services were regulated and their resulting governance structures to promote both economic and clinical efficiency. One of the transformations evidenced throughout North America includes a restructuring of all healthcare delivery systems with an emphasis on community-based care, also known as ambulatory care.[8]

The economic and social impetus to develop community psychiatric practices for severe mental illness will be further discussed Chapter 1, however it is largely accepted that ACT is an evidence-based program[9] intended to respond to service users experiencing mental health problems that are considered to be severe and persistent and who are also identified as unstable or vulnerable (Government of Québec, 2012). Community care models such as ACT often purport to support quality of life in the community, that is, outside of the confines of the mental health team or institution; service users of these programs are living in independent housing or supportive housing in the community. These models are seemingly in communion with values and principles of recovery-oriented care because they are community-based and because the intensity of contact with service providers outside of the asylum might presume a

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[7] New Public Management (NPM) is a paradigm entrenched in a neoliberal perspective, which holds the belief that the State and public sectors are dysfunctional and that the market, or private sector, is more efficient. Consequently, NPM is characterised by a focus on decentralisation, accountability, cost reduction, and public-private partnerships (Jetté & Goyette, 2010; Varone & Bonvin, 2004).

[8] For further discussion on these changes please see Bourque (2009), Groulx (2009), White (2005).

[9] Evidence-based practice (EBP) refers to mental health treatments or interventions that are empirically supported; typically, in the tradition of evidence-based medicine, this does not include experience-based knowledge.

culture of care based on hope and dignity.[10] Current psychiatric services in North America, including Québec, are typically aligned with some form of recovery rhetoric and attempts at reframing ACT programs as recovery-oriented are underway (Salyers & Tsemberi, 2007; Salyers, Stull, Rolline & Hopper, 2011) and in Québec began with discussions regarding the relationship between ACT programs and rehabilitation (Gélinas, 2002). However, critics of the recovery approach (Coleman, 2004; Hopper, 2007; Pilgrim, 2008, Slade, Amering, Farkas, Hamilton, O'Hagan, Panther, Perkins, Shepherd, Tse, & Whitley, 2014) point out that it is often difficult to operationalize within psychiatric, or public mental health, systems.

Empirical evidence of the successful implementation of professional practice that incarnates recovery values in public mental health services is almost inexistent. The way in which and the degree to which mental health practice at the community level, and primarily practices in the ACT program by nature of its *raison d'être,* are implicated in accompanying service users living in the community on their recovery journey is not yet known. Since the era of deinstitutionalization, during which transformations in mental health care led to the closure of many asylum beds and a transfer of most care and services to the community (Dorvil, 2005), the focus has been on negotiating community partnerships, emphasizing individual responsibility and cost efficiency, and more recently on including a recovery-oriented clinical stance. Several questions arise: Although recovery in policy is presented in conjunction with participation and citizenship (Government of Québec 2005, 2015), what kind of recovery are we talking about; what is understood and meant by participation and citizenship in policy and

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[10] Since the 1970s mental health community organizations in Québec have included services, accompaniment, and political influence based on practice innovations. They have a long standing tradition of offering mental health care that is « *alternative - ailleurs et autrement* » (RRASMQ, 1999) meaning that care and accompaniment is offered outside of the confines of the hospital or institution and is not exclusively focused on or reduced to pharmacological treatments or restrictive biomedical understandings of mental health issues.

in the context of mental health care design and delivery? Is the meaning of mental health recovery and recovery-oriented practice vulnerable to the organizing principles of the dominant biomedical[11] vision of mental health care and the New Public Management paradigm? Has the initial, emancipatory, radical significance of mental health recovery become "diluted as the practicalities of service provision are meted out, focusing on outcomes" (Bonney and Stickley, 2008, p.149)? Do actors in a specialized care community mental health team in Québec hold conflicted or coherent understandings of recovery and recovery-oriented mental health practice? What new innovative practice approaches have developed in the public mental health sector with the proliferation of community mental health care?

Current debates and discussions on the usage and implementation of a mental health recovery orientation at an international level have involved a variety of interest groups and stakeholders including mental health service users and citizens, mental health professionals, academics, non governmental organizations (NGOs) and more recently governments and public health services such as ACT programs. From a micro (clinical) perspective, there is the position that public mental health services, such as ACT programs, are ideally organized to support members of society in their mental health recovery and can assist them in contributing to community life and regaining their social citizenship (Rowe and Pelletier, 2012). However a more meso- and macro- perspective might consider the position that public mental health services, specifically community-based services, not only impact upon society as social actors

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[11] This refers to the power of the medical authorities in psychiatry today (McCulloch et al., 2005) which postulate a purely biological causation and chronic outcome of mental illness

but also have immense influence as political and cultural actors[12].

Larry Davidson and his colleagues (2006; 2009; 2010) have suggested that the potential for mental health service design and delivery transformations as a result of the mental health recovery movement require changes, not in mental health service provision, but rather more fundamentally in the “status and role of persons living with mental illnesses” (Davidson et al, 2010). People living through extreme situations and experiences, such as social exclusion and mental health problems, may be unable to exercise their citizenship and participate in society in the way that they might like. ACT is considered the program of choice in the public health care sector to respond to the clinical needs of marginalized, excluded people with serious mental health problems living in the community. However, the community care model inherent in this program might be well positioned to also attend to other barriers and facilitators of mental health recovery, namely social, political, and economic circumstances. Thus, the ACT program is a privileged space to study potentially innovative mental health practices that aim to reduce barriers to inclusion, such as stigma and discrimination, which may renegotiate the social position of people living in extremely marginalized situations. As such, this research positions the ACT program as a political, cultural and social actor nurtured and privileged by the State to respond to the needs of socially excluded individuals living with severe mental health problems. What role do community mental health programs, such as ACT, have in influencing positive changes in the opportunities, rights, respect, and entitlements accorded to marginalized, excluded citizens living with mental health problems?

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[12] This will be further discussed in Chapters 3. Briefly, community mental health programs interact frequently with others at the individual and collective level in turn shaping the construction of meaning of many contemporary issues including mental health, recovery, and citizenship.

This dissertation is located within the field of social work. It uses a transdisciplinary approach drawing on the field of social work itself, as well as sociology, psychiatry, and political science. It builds on already existing work on mental health recovery and citizenship from a mental health professional and academic perspective (e.g. Anthony, 1993; Carpenter, 2002; Chen et al., 2013; Davidson et al., 2009; Kidd, Kenny & McKinstry, 2015; Lietz et al., 2014; McCranie, 2011; Pilgrim, 2008, 2009; Provencher, 2002; Rodriguez, Corin et Guay, 2001; Rodriguez et al., 2006; Slade et al., 2014), from the perspective of persons with lived experience of mental health problems (e.g. Deegan 1988, 1997; Chamberlin, 1997, 1998; Ridgway, 2001; Mead & Copeland, 2000; Piat et al., 2009), and from a socio-political perspective (Clément, 2008; Lamoureux, 2001; Pelchat, 2010; Young, 1989) that considers both policy rhetoric regarding mental heath, recovery, and citizenship as well as societal attitudes towards these constructs. This research contributes to these bodies of knowledge by combining theoretical perspectives on recovery and citizenship in order to explicate the complex processes and interactions related to extreme marginalization and exclusion.

There are many calls from researchers for social workers to lead efforts to address barriers to developing recovery-oriented services and practices (Gomory et al., 2011; Lietz et al., 2014). Practically this means that social work's hallmark perspective of interaction between individuals, groups and communities, and its critical reflection of the social aspects that influence situations and problems, offers the opportunity to connect with recovery values and broaden the scope of recovery research beyond mental health problems and symptoms. Mental health social work, in Québec and elsewhere, has developed interventions and guidelines entrenched in the discipline's holistic perspective to empower people in their interpersonal relationships, in attaining desired social roles and in exercising their rights as citizens (OTSTCFQ, 2013). For example, empowerment and strengths-based perspectives (Rapp, 1998) proposed a radical shift: moving the focus on illness or deficit to the background and instead focusing on strengths or resilience as the most effective path to recovery. There exist congruencies in the underlying core values of social work[13] and of recovery (Carpenter, 2002; Khoury & Rodriguez, 2015; OTSTCFQ, 2013; Pilgrim, 2009; Shera, 1996); values that include the inherent worth of every person, equality, and dignity (Cohen, 1995; Corrigan & McCraken, 2005; Davidson et al., 2006; Jacobson and Greenley, 2001; Manning, 1999). Social work professionals and authors (OTSTCFQ, 2013; Rodriguez et al., 2000, 2002, 2006; Corrigan & McCraken, 2005; Gomory et al., 2011) have discussed the importance of the psychosocial and socio-political conceptions of suffering and of promoting recovery, citizenship, empowerment, and wellness in mental health care settings. Collaboration between community social workers and mental health rights movements is less documented but very active. These affiliations have contributed to the emergence of community intervention practices that provide an alternative to reductionist biomedical approaches (Rodriguez, Corin and Guay, 2000). By reductionist, I am referring to the risk of oversimplifying mental health problems as only a biological disorder and thus focusing on reducing psychiatric symptoms through a singular intervention of pharmacological treatment.[14] These alternatives include,

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[13] According to the Canadian Association of Social Workers (CASW) Code of Ethics (2005), the professional core values and principles include : respect for the inherent dignity and worth of every person ; pursuit of social justice ; service to humanity ; professional integrity ; confidentiality ; competence in professional practice. The Internation Federation of Social Workers (IFSW) also lists human rights and social justice as “fundamental to social work” (2000, para.1)

[14] The positive role that psychiatric medication has played in the lives of many service users is not dismissed. However, the traditional, single-minded focus on psychiatric medication as the only effective avenue of intervention is contested and this contestation is supported by many empirical studies (Davidson et al., 2009; Rodriguez et al, 2000; Rodriguez et al., 2013; Rodriguez et al, 2014) as well as service users and activists.

but are not limited to, attending to the subjective experiences of service users, repositioning mental health problems in the context of the person's life trajectory, establishing an open dialogue, defending human rights and social justice principles in order to improve the material and societal conditions of the person. The importance of attending to social conditions and inequalities is central to a social work perspective. By considering the impact of poverty, exclusion, isolation, insecure housing, poor physical health on the mental health and mental health recovery or people, social work can offer a unique and privileged position to exploring the meaning of recovery and, as named most recently in Québec policy, recovery through citizenship.

The primary intention of this research was to explore the concept of recovery and explore the lived experiences of those participating in an ACT program through the viewpoints and daily actions and interactions of various stakeholders. In order to better understand the impacts, if any, of the biomedical approach, of the recovery rhetoric in policy, and of the structuring effects of managerial perspective[15] on practice I will analyze social actions and interactions in relation to the stakeholder understandings of mental health recovery, inclusion, participation, and citizenship. I expect that the diverse actors in the mental health scene do not necessarily define recovery or recovery-oriented practice in the same way as the MHAP but instead have their own ideals or values of what recovery is or looks like. Going beyond the elusive and vague definition in the MHAP, I am examining not only recovery as it is defined in policy, but also as it is described by participant discourses and as it is observed in concrete practice techniques in ACT teams. In this way, the results of this dissertation will fill

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[15] This refers to a perspective of managing the mental health system with a results orientation, generally requiring quantitative inputs in order to measure and evaluate performance outcomes of individual service providers, care teams, and organisations

a gap in the empirical literature in Québec by providing a local, contextualized understanding of how service users and service providers interact in an urban ACT team. This will allow for an explication of the complex, negotiated, innovative and local nature of social scenarios in an ACT program that are not identified in traditional fidelity scales or current descriptions. Moreover, this study is innovative in its attempt to reframe the role of community mental health programs within a larger social and political perspective that includes understanding the intersubjective influences that stakeholders have on each other, on the local community, and on society and questioning the place occupied by social factors in the interactions.

In short, through a bottom up perspective, this dissertation proposes a contextual and local examination of the complex social interactions in an urban ACT program in Montreal, Québec through the lens of various stakeholders[16]. What kinds of interactions and interventions is the participating urban ACT program producing (or reproducing) on the streets and in the neighbourhoods of downtown Montréal? Is the program harnessing the opportunity through its organizational structure to welcome positive transformations in practice and participation? Do ACT service providers negotiate the meaning and construction of interventions with service users? In what way does the ACT program offer support and accompaniment that is meaningful to service users and coherent with their personal recovery process? These questions are relevant because the way in which community mental health interventions, particularly within an ACT program, are implicated in accompanying service users in their community of choice and in their recovery process is not known.

This study does not seek to evaluate the ACT program nor does it aim to provide an exhaustive detailing of social interactions within an ACT program. Through the study of a

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[16] In order to avoid the pitfalls of a normative understanding of recovery, mental health, community

specific ACT team in Montréal, this study is focused on exploring the interactive and intersubjective dynamics of social actors – in this case service users and service providers - using ethnographic methods of participant observation and semi-structured interviews (n=18) over a 7 month period in 2014. Thus, this study highlights interactional practices that create meaning rather than top down institutionalized definitions of practice approaches. Subscribing to an interpretive research paradigm, the study of the interactive construction of social order and the lived reality of participants is a way to reflect the singular meanings, values, experience, opinions, and behaviours of the participants (Berger and Luckmann, 2006; Mayer et coll., 2000; Moustakas, 1994).

In response to several authors regarding the challenges in understanding the diverse practical scenarios that shape recovery-oriented care (Pilgrim, 2009), this study takes an approach that allows for an in-depth and practice-near study of daily social interactions of various actors. This is particularly relevant given the finding that ACT teams have not been disseminated evenly across Québec (Government of Québec, 2012) and elsewhere such as the USA (Deci et al, 1995) and the Netherlands (Van Dijk et al., 2009). Thus, notwithstanding notions of fidelity scales and attempts to obtain and maintain high fidelity to the ACT program model, in reality it seems that every team is highly specific and heterogeneous. This examination will explicate the co-produced social universe of an urban ACT program in Montréal which will in turn assist us in identifying local, context specific best practices, obstacles, and facilitators to implementing these practices in order to contribute to the community life and citizenship of people with a lived experience of mental health problems.

Outline of dissertation

The presentation of this research study is divided into 3 parts, which includes a total of eight chapters. The first part includes Chapter 1 and Chapter 2. It presents the problematic that is under investigation and offers an exhaustive literature review regarding both Assertive Community Treatment programs and the Recovery orientation. Following is Part 2, which outlines the research design that was conceived of for this study. Part 2 includes Chapters 3 and 4. The third chapter reveals the theoretical perspectives guiding this study, including my ontological and epistemological positioning. The fourth chapter is dedicated to explaining the methodology and research methods used in this study. Chapter 5, 6, 7, and 8 make up Part 3 of this dissertation and they offer an analytical presentation and discussion of the results that emerged form my observations and interviews. The final chapter will provide an in-depth discussion and conclusion in order to illustrate the contributions that this research project has in furthering our knowledge of mental health recovery-oriented practice and the potential for community mental health programs to expand the scope of their impact in the current organizational and political context.

Part 1 – Literature review and problem statement

Addressing the paradoxes of recovery and ACT: from theory to practice

When service providers enter into direct practice situations, the approaches and theories that guide their perspectives may be confronted by a multitude of real world complexities including their particular organizational contexts, orientations, and interactions. Thus, the construction of interventions might be influenced, sometimes implicitly, by not only the service provider's professional base, but also by their institutional context of practice and their intersubjective relationship with service users. Awareness and understanding, through critical reflection, of these potential influences on practice can help service providers juggle with the sometimes confusing and often complex situations that emerge (Fook & Gardner, 2007; Healy, 2005). The combination of context, orientations, and relationships in a specialized community based mental health team, in a policy era of recovery, citizenship and neoliberalism, may represent a space in which complex, situated, and sometimes paradoxical actions and interactions occur.

The relationship between organizational contexts and policy frameworks as well as professional paradigms in mental health practice have been explored in different ways and in many disciplines: Foucault (1972, 2003)[17], whose seminal works on madness and society, on the role of control and punishment, and on the medical gaze offer necessary foundations to understanding society's relationship with madness; Goffman (1961) and Barrett (1996)

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[17] Foucault's discourse around power and language is predominant in texts relating to social work practice and to analyses of agencies or organizations (Chambon, Irving & Epstein, 1999).

explored the inner workings of asylums with a sociological and anthropological eye in order to explicitly raise questions about relationships and interactions in those spaces; Estroff (1981) also used an anthropological field study to understand the life contexts of psychiatric service users living in the community; Rodriguez (2011), Poole (2011), Gomory et al. (2011), Cohen (1995), and Pilgrim (2008, 2009) are just a handful of social work researchers in Canada, the United States, and the United Kingdom whose work demonstrates the paradoxes and controversies in recovery-oriented practice and alternative approaches to mental health within the current social, political, and economic context. Bourque (2009), Hawkins, Fook & Ryan (2001), and Healy (2005) are specifically concerned with the strategies social workers might use to adjust to the contextual dynamics, such as the neoliberal push for New Public Management policies focused on efficiency and efficacy, affecting practice.

The intersection of contexts and paradigms such as recovery, community mental health, participation, citizenship, and managerialism will be unpacked by first exploring the evolution and current state of affairs of ACT programs (Chapter 1) and then by doing the same with regards to the recovery orientation (Chapter 2). Throughout these chapters the possible challenges to achieving a recovery-oriented Assertive Community Treatment practice approach will be questioned.

Chapter 1: Assertive Community Treatment Programs

This section will begin by sketching a high-level description of ACT programs, in an historical context, particularly in Québec. The depiction will highlight the different concerns and contradictions found in the literature regarding mental health practice in this particular program model. I will also explore the challenges that might occur when ACT is designated as the model of choice to respond to the needs of marginalized people with serious mental health problems living in the community. This problem statement (paradoxes, constraints, concerns) of community mental health practice, particularly in an ACT program, is an opportunity to provide a baseline for observing and interpreting the process of daily actions and interactions amongst service providers, service users, and other stakeholders that may influence the construction of practice and interventions.

1.1 The development of Assertive Community Treatment Programs in Québec: historical perspective and current state of affairs

The historical evolution of community mental health practice, specifically ACT programs, as well as the current state of affairs in the field, will be fleshed out in order to provide a socio-historical context from which to underscore potential paradoxes within the domain of an ACT program.

This background information will offer an overview of the ACT program over the last several decades since the onset of deinstitutionalisation.[18] It will also provide an understanding of the place it has within psychiatric services today, in the development of recovery-oriented approaches, and its role as a player in helping us understand the evolution of community mental health care.

1.1.1 Development of ACT – an explanation of the model

The ACT program is a model that was initially developed in the United States, at the Mendota State Hospital in Madison, Wisconsin, within the organizational framework of a psychiatric team as an alternative to hospitalization in the context of deinstitutionalization. It was conceived in the wake of the Community Mental Health Centers Act in the United States in 1963 (Test & Stein, 1976) as a way to fill the gap between the abundance of professional resources in the psychiatric institutions (read: asylums) and the lack of such resources in community settings (Dorvil, 2005). The treatment approach used the social learning model[19] (as opposed to individualized psychotherapy) and the objective was to provide comprehensive outreach in the community where patients could access the same type of treatment team they would have access to if they were in the hospital. Drake and Burns (1995, p.667) put it succinctly when they wrote, over 20 years ago:

> "The central idea of assertive community treatment was that a community-based team would provide a full range of medical, psychosocial, and rehabilitative services, analogous to care in a hospital, to prevent hospitalization of clients...".

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[18] Because ACT programs were first developed in the United States, literature from that country, as well as others, allow for a solid understanding of the program. However, the present study is focused on the Québec reality and thus a significant proportion of the literature comes from this Canadian province.

[19] Although today we note a marked emphasis on psychoeducation with a strict focus on acquiring skills and meeting predefined goals (Poirel, 2011; Rodriguez, 2011)

Hospital avoidance, central to the ACT model, is why it is predicated on assertive and frequent contact to avoid 'clinical decline'.

ACT is defined in the literature as providing round the clock, individualized, specialized psychiatric services in a person's home or community (Drake & Burns, 1995). The ACT model is widely considered to be an evidence-based model of care that is described as having a set of 'critical ingredients' that can be replicated and repeated in various settings (Bond & Drake, 2015; Bond, 1991; Bond et al., 2001; McDonel et al., 1997; Rodriguez, 2011; Phillips et al., 2001; Teague et al., 1998). There have been numerous randomized controlled studies on ACT; it is regarded as a best practice due to the norms and standardization that support it[20] and purport to allow for its replication in diverse settings. These studies define success and quality based on quantitative outcomes such as reduced hospitalizations and cost reduction (Latimer, 1999; Teague et al., 1998), as well as patient to staff ratio and number of contacts between the two, and increased functioning and quality of life of service users as assessed by a 31 item scale (McDonel et al., 1997).

Team and functioning

An ACT program should be composed of an interdisciplinary team of 6-9 service providers for an average 70 service users per program, giving a ratio of 1/8 to 1/12 service providers/service users (Government of Québec, 2005). Included in those service providers, is a ratio of almost 3 nurses (2.85) for 100 service users. The program is not evaluated in Québec on the ratios of other professions. However, in Québec, service providers almost always

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[20] Using for example scales such as the Dartmouth Assertive Community Treatment Scale (Teague et al., 1998) to help maintain model standards. An updated version of this fidelity scale incorporates assessment of recovery-oriented services (Bond and Drake, 2015) and is currently used by the Centre National d'Excellence en Santé Mentale (hereafter, CNESM) in Québec.

include a doctor, and a combination of nurses, social workers, psychoeducators, and addiction specialists (CETSQ, 1999).[21] According to the Tool for Measurement of Assertive Community Treatment (hereafter, TMACT), which is used as an evaluation tool by the CNESM, each team must have a team leader with full clinical, administrative, and supervisory responsibility who also engages in direct practice with service users. The psychiatrist on the team is supposed to educate the non-medical staff on medications, collaborate with nurses and the team lead, and attend team meetings. The psychiatrist's medical care provision includes monthly assessments of service users' responses to medication, brief therapy, psychoeducation regarding diagnosis and medication, home and community visits and liaising with admitting units.

Adherence to the TMACT also requires daily team meetings with all staff members to plan daily contacts with each service user. These meetings should also be used to conduct a review of all service users and any contacts with those service users in the last 24 hours.

Services and approaches

By definition, the ACT program offers a complete range of mental health care services, including individual psychoeducation, medication treatment, and elements of case management (CETSQ, 1999; Thomson et al., 2002) in proximity to the service users' life in the community. This means that services and interventions extend outside of the office walls and into service users' homes or community based locations such as cafés. The TMACT indicates that an ACT program must provide 75% of contact with service providers in the community. These "community-based services" (Monroe-Devitta et al., 2013) are defined as bringing services to individuals who have historically not been well served through office

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[21] These service providers are seen as interchangeable and thus their interventions are not dependant on their professions, ensuring a continuity of service (Poirel, 2011) and an important deviation from traditional case management models.

based interactions and interventions. It also refers to developing skills and monitoring service users in the community rather than in a clinic.

According to the CNESM (2008) in Rodriguez (2011), these services aim to provide treatment, rehabilitation, and support. One ACT service provider explained the services in her team as ranging from a systemic approach to one focused on problem solving and risk management with the goals of providing treatment, rehabilitation, and recovery (Poirel, 2011). The TMACT specifically refers to promoting self-determination and independence, engaging in person-centred planning through treatment planning and Individualized Intervention Plans, and using strength-based focus for the purpose of treatment planning. In order to respond to a broad range of life domains the team must use the following models: supportive housing, supported employment, and integrated dual disorders treatment. The most recent mental health action plan in Québec (Government of Québec, 2015) cites the necessity for peer professionals to be integrated into the clinical care team as part of a broader recovery orientation.

Recovery is mentioned directly in the TMACT under the item "full responsibility for wellness management and recovery services" (Monroe-Devitta et al., 2013). This item refers to Wellness Recovery Action Plans (WRAP) and usage of Illness Management and Recovery (IMR) training manuals (more on this in section 1.2 below).

Characteristics

The TMACT fidelity scale also indicates the importance of social networks and natural supports – ideally an ACT program is in touch with the natural support system of each service user once a month. However, two defining features of the ACT model, other than close proximity interactions, are flexibility and autonomy for service providers. The intended goal is to be able to offer individualized treatment that can easily and quickly adapt to the complex circumstances of the service user. In addition, this flexibility and room to manoeuvre is meant to support service providers in the goals of offering round the clock care and treatment in the community instead of the clinic or agency. As with the original ACT program model in Wisconsin this follow up is not time limited (Bond et al., 2001; Poirel, 2011, Rodriguez, 2011).

The literature denotes the 'assertive' aspect of ACT teams as the intensity and persistence with which the treatment team engages reticent service users. Contact between service providers and service users is frequent and can range from 2 to 15 times a week (CNESM, 2008 in Rodriguez, 2011). The TMACT refers to a high amount of face-to-face interactions with a goal of 2 hours a week or more per service users over the course of at least 3 meetings. Although "outreach stresses relationship building" (Bond et al, 2001), the concerns about intense and assertive practices blurring with coercive practices in the ACT program abound in the literature (Dorvil, 2005; Gélinas, 2009; Gomory, 1999; Rodriguez, 2011; Thomson et al., 2002).

1.1.2 ACT programs: supported by the development of community mental health services in Québec

Over the last 60 years in North America, and elsewhere (UK, Italy, Australia), the mental health systems in place have experienced important changes in the service design and delivery. The asylum period of care in Québec existed from the opening of the first asylum in Montréal in 1839 to the beginning of the period of deinstitutionalization in 1962. In the asylums, treatment was characterized by mostly involuntary long term hospitalization focused on remedying 'moral disorders'[22] (Paradis, 1993 as cited in Fleury & Grenier, 2004); this contributed to the social exclusion and stigmatization of those labeled as 'crazy', an already marginalized group. This discrimination led to the abusive and inhumane treatment methods[23] used in institutions (read: asylums) that were collectively ignored by most members of society.

The period of deinstitutionalization that began in Québec in the early 1960's was pre-empted, in part, by pharmacological discoveries and a modernist psychiatric paradigm. The introduction of chlorpromazine[24] resulted in earlier discharges, reduction in hospital beds, inauguration of an open-door policy, and a reduction in the more primitive treatments such as lobotomies and long-term incarceration in the asylum (Cancro, 2000; Lopez-Munoz, Alamo, Rubeo & Cuenca, 2003).

It is important to recognize that the impetus to reduce symptoms and discharge patients into the community also came from social pressures external to the psychiatric system, which contributed immensely to the phenomenon of deinstitutionalization. In Québec, the Quiet Revolution in the 1960's was the social movement that resulted in an increase of governance by civil society. It provided the opportunity for different groups to have a voice; mental health patients and their supporters, mainly community based mental heath organizations, denounced the inhumane treatments they were receiving in the asylums and in society in general.

In 1961, the government instated the *Commission Bedard*, which made 50 recommendations for improving the mental health system. Following the recommendations

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[22] Fleury & Grenier (2004, p.39) state that according to Philippe Pinel, the grandfather of modern psychiatry (1801), the appropriate treatment was isolation from the environment that led to the bad habits that in turn caused the moral problems.

[23] The beginning of the 20th century was characterized by insulinotherapy, lobotomies and electroconvulsive therapy (Cancro, 2000) in order to control the patient. In this asylum model of care, "the use of physical restraints was pervasive…dignity was in short supply" (Cancro, 2000, p.334).

[24] The discovery of neuroleptics, such as chlorpromazine in 1953, as well as the influx of modernist psychiatrists after World War II who were seeking objective, scientific and universal solutions to mental illness positioned mental illness as a curable disease and therefore pertinent for the medical community.

from this commission the *Rapport Bedard* was released in 1962. It explicitly called for a step back from the asylum model of care by focusing on community based care and community organizations. Every general hospital was to create 200 beds for psychiatry and psychiatric hospitals replaced asylums (Fleury & Grenier, 2004). The *Rapport Bedard*, and the subsequent "adoption of the concept of community psychiatry" (Rousseau, 1993, p.535) marked the beginning of the development of public community mental health services, which eventually included ACT.

However, the massive wave of deinstitutionalization struck society with such speed and force that the appropriate community services and supports were not developed in a timely manner. This led to a tragic result of many people living with mental health problems forced into precarious situations of homelessness or in the criminal justice system (prisons were not the resources targeted by deinstitutionalisation) (Dorvil, 2005; Rowe and Baranoksi, 2011). In response to this wave of deinstitutionalization, the decades following the *Rapport Bedard* and the Quiet Revolution reinforced the emergence of mental health rights organizations in Québec that denounced the living conditions in asylums, still in existence in the 1970s, often through the organized movement of psychiatric survivors and allied service providers who denounced the conception of mental illness as a medical problem to be treated like any other illness[25]. In tandem with this emergence of the mental health community sector, the

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[25] The ex-psychiatric/survivor movement is considered to be a social movement that argued that mental health problems are not caused by a brain illness and that a cure is not the paramount objective. It posits that injustices and inequalities are ingrained in psychiatry and society. The movement promotes alternatives to care. For more reading please see Morrison, L. (2005). Talking back to Psychiatry. This movement also has policy implications: resolving mental health problems is not the sole responsibility or expertise of an all-powerful medical professional. More recently the landmark report by the Standing Senate Committee on Social Affairs, Science and Technology, known as the Kirby Commission (2006) advised that "treating mental illness like physical illness is best understood to mean that both types of illness must be treated with equal seriousness, by providers, by all Canadians — and particularly by governments" (p.41). This report purported to bring mental illness "out of the shadows" and place recovery at the centre of the federal mental health political landscape.

Castonguay-Nepveu Commission (1966-1970) preceded the creation of socialized health insurance in Québec and structured the public health and social services system. The Commission is associated with a secularisation of Québec's health and social services and a modernizing of the State following the Quiet Revolution in Québec. With the creation of institutions such as the Ministry of Social Affairs, regional health and social services councils, health insurance (RAMQ), and local community services centres (CLSC) the government was attempting to manage health and social services at three levels of governance: provincial, regional, and local (Turgeon, Jacob & Denis, 2011).

The 1980's were significant in that a serious economic recession, coupled with a global conservative political climate, led to many cuts in social and health programs. Québec's unions, mobilized citizens, and attachment to the Welfare State buffered it from some of the effects of these changes; moreover, a resurgence of community groups in the early 1980's responded to the needs of citizens in place of the State. In 1987, the *Rapport Harnois* served as the basis for official government policy on mental health service organization. This report is the result of work undertaken by another committee, known as the *Commission Harnois*, charged by the Québec government with preparing a policy paper for mental health. The president of the committee was Dr. Gaston Harnois but the committee itself included representation from several groups including psychiatric survivors. The aforementioned social movements and community, rights and alternative mental health movements in Québec were highly influential in the creation of this committee.

The Harnois Commission submitted a report entitled *Pour un partenariat élargi,* in which they critiqued the way deinstitutionalization was handled. It stipulated the gross under-funding of community resources and the need for a stronger partnership with the community sector in order to alleviate the State of its responsibility to society as well as to articulate a more prominent inclusion of users of the system in decision-making (Government of Québec, 1987).

Shortly thereafter, the *Politique de Santé Mentale* (1989) was born out of several years of deliberation in which the State recognized that the intended evolution of mental health practice had not taken place; the biomedical perspective at the institutional level being too prevalent to allow for adequate development of services in the community and the neo-liberal perspective at the government and societal levels did not support financing the necessary services. The overarching directive of the *Politique de Santé Mentale* included an emphasis on a biopsychosocial approach to care along with improved integration of services in the community (Government of Québec, 1989). The legacy of this policy is that it recognized the central position of the person living with mental health problems; thus mental illness began to be reframed as mental health.

The 1990's were a period of change in the regulation of the health care system due to globalization, economic pressures, and socio-demographic changes. This led to changing parameters within the health and social services system, including, but not limited to, the incorporation of a neoliberal ideology, a public sector economic goal of zero deficit, the emergence of New Public Management (NPM) as an administrative approach, and increased accountability for evidence-based practices (EBP).[26]

In partial response to these emerging and highly influential factors, the Government of Québec's *Ministère de la Santé et des Services Sociaux* (MSSS) recommended the implementation of ACT programs as early as 1998. The stated goal, initially, was to improve

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[26] For further discussion on these changes please see Bourque (2009), Groulx (2009), White (2005).

service integration and succeed where past attempts at deinstitutionalization failed (Dorvil, 2005, p.228). In 1999, a report by the *Conseil d'évaluation des technologies de la santé du Québec* (CTESQ) reviewed the literature on ACT programs, focusing on their demonstrated efficiency and positive effects on service quality. The conclusion of this report was that Québec should adopt the ACT program on a large-scale basis and remain close to the fidelity scales found in the literature in order to respond to the policy objective of reducing hospital beds and other NPM directives of improved cost efficiency. What followed was the development of ACT programs in Québec alongside other community based mental health service models such as psychiatric external clinics, day hospitals, and crisis centres to respond to the complex needs of services users whilst they continue to live in the community. These other community based mental health service models had already begun to promulgate in response to deinstitutionalization and the development of ambulatory care in the 1990s. Under these conditions, the government of Québec began to rethink the ways in which the public health and social services system is regulated and the resulting governance structures. The neoliberal context in which this regulation and oversight was beginning to modify the health and social services system emphasized efficiency, both economically and clinically. Notions of community responsibility and a sharing of responsibility in the public sector also supported the principles of efficiency, cost reduction, and accountability. This call to other actors or stakeholders to also be responsible for the well-being of citizens was new and was indicative of the retreat of the State in the matters of health and social services in order to adapt to changes in the socio-economic context.

Historically, the MSSS mental health policies refer to partnership, collaboration, and coordination of services. However, in 1998, the MSSS's *Plan d'Action pour la transformation* *des services en santé mentale* began to refer to 'integration of services'. Whilst elaborating the *Plan d'action pour la transformation des services en santé mentale,* the MSSS called for a clarification of the concept of empowerment; a committee called *Le comité de pilotage du Guide d'appropriation du pouvoir*, which was made up exclusively of mental health service users was in charge of defining the concept of empowerment (Blais, Bourgeois, Judon, Larose & Lecompte, 2004 as cited in Rodriguez et al., 2006). They worked in collaboration with the *Comité de la santé mentale du Quebec's* service quality working group and together they contributed to the definition of empowerment used by the MSSS in 2004 in the document entitled *Guide pour le developpement des competences en santé mentale.* As cited in Rodriguez et al. (2006, p.114) the guide included the following excerpt:

> *"l'appropriation, par une personne utilisatrice de services en santé mentale, du pouvoir quant à la conduite de sa vie est un processus continu qu'elle-même a décidé d'entreprendre et qu'elle gère en fonction de la connaissance qu'elle a d'elle-même et en fonction de ses expériences, de ses besoins et de son parcours. Ainsi elle peut prendre la parole en toute liberté, exercer ses droits et assumer ses responsabilités librement et de façon éclairée, décider de toutes les facettes de sa vie, tant sur le plan individuel que collectif, et défendre ses droits."*

This guide preceded the landmark Québec Mental Health Action Plan (MHAP) in 2005. This provincial policy particularly affected mental health care service organization and practice in Québec, partly due to its timing during a major upheaval of the structure of Québec health and social services delivery system.[27] In addition, this policy explicitly named the

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[27] In December of 2003 the Québec government began a major reengineering of the health and social services network in the context of modernizing the State using a health services integration model (Perron, 2005, p. 162). Initially proposed by Bill 25, la *Loi sur les agencies de développement de réseaux locaux de services de santé et services sociaux*, and later replaced by Bill 83 in 2005, this reengineering included a change in governance to reorganize services in an integrated, local manner, to increase accessibility to services and to improve performance of the system (Government of Québec, 2010). Bill 83 supported the proposals initiated by Bill 25 by creating local and supraregional networks to improve the efficiency of the system as well as respond to the health and social services needs of an entire population on a local territory. This is considered a direct application

orientation of recovery as a directive and as a new perspective with which services should be organized. As with past policies in Québec, the MHAP emphasizes the centrality of the person with mental health problems in the construction of interventions. It also focuses on 4 directives other than recovery: accessibility to local services; continuity of care; partnership between the institutions and community organizations; and efficiency (Dorvil, 2005; Government of Québec, 2005, p.12). In this way, the MHAP demonstrates an evolution in the concept of community based care. After the *Rapport Bedard,* community based care referred to psychiatric departments in general hospitals, whereas the contemporary MHAP envisions community based care as including the community sector and interdisciplinary community based mental health teams. In addition, this policy in anchored in strong primary care services. This not only displaces the role of the psychiatric hospital, but also leads to programs that are structured in a way that costs less. In sum, the goals of the MHAP are to offer the required mental health services in the service user's community and to adopt a model of shared care based on partnership, liaison, and a hierarchy of services.

The ACT program (intensive community follow up) as well as variable community follow up programs were earmarked as cornerstones of the MHAP as a way to maintain adults living with severe mental health problems in a community setting (ie. not in the hospital). Specifically, ACT is referred to as a program that can address the needs of people whose "mental health condition is instable and fragile" (Government of Québec, 2005, p. 51, author's translation). In June 2008, the Québec government established the *Centre National d'excellence en santé mentale* (CNESM) to support the development of best practices within

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of principles of NPM wherein Welfare state services are given to decentralized organizations and are controlled via budget and results (Lariviere, 2005; Merrien, 1999).

the ACT programs in Québec. Its mandate is to define and promote best practice and clinical criteria for community support programs, such as ACT, through training, support and evaluation. At the time of the data collection of this research project (2014) the latest MHAP 2015-2020 had not yet been released. However, this MHAP 2015-2020 reiterates the definition of ACT programs as part of a continuum of community support models put into place in Québec to ensure an efficient service offer that reduces hospitalizations and maintains individuals with severe and persistent mental health problems in the community. However, several studies and reviews indicate that the impact of ACT on outcomes other than hospital use is unclear (Bond and Drake, 2015; Goscha et al, 2012). The recent emphasis on the recovery orientation within the ACT model (Salyers and Tsemberis, 2007) accentuates the contradictions in place between the foundational hospital-centric philosophy of the ACT program and the progressive social model of the recovery orientation. This will be further discussed in the following chapter.

Although today's public mental health landscape includes a plethora of community mental health models (ACT, variable intensity follow up and non-intensive basic support)[28], they originated, in part, in the innovative practices developed by community and alternative mental health organizations in Québec. Rodriguez (2011) discusses at length various community support models by comparing and contrasting the practices in institutional settings and those in alternative mental health settings with a focus on practices that emphasize social

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[28] Non-intensive basic support is a model that will be implemented in Québec in 2017. The difference between intensive community follow up (ACT) and variable intensity follow up lies not only in the number of face to face contacts required between service providers and service users but also in the composition of the team. Since variable intensity follow up teams do not require a psychiatrist or nursing staff and they follow a case management model, there are many regions and territories in Québec in which this service is offered by the community sector, rather than the public sector.

inclusion. The author's analysis focuses on the varying types of interventions that emerge in different settings despite these settings sharing common orientations such as recovery and person-centred support. In other words, Rodriguez (2011) proposes that diverse community based practice settings are developing specific types of mental health support based on their particular agency culture and background, rather than developing homogenous practice approaches based on an overarching orientation. For example, alternative mental health community organizations speak of 'accompanying' citizens rather than offering a 'follow up' to service users (Rodriguez, 2011). Accompaniment is a term and concept that is being used more and more in institutional settings and within ACT programs (Rodriguez, 2011), but with seemingly different practice implications. One of the distinguishing factors of community mental health follow up in the community sector is the recognition of social and economic causes and responses to mental health problems and the centrality of participation of people living with mental health problems. The role of the service provider is to accompany the person in regaining power in her life. However, a reductionist biomedical hegemony and the precarious state of citizenship rights for people living with mental health problems remains an important challenge in public sector services where 'follow up' usually denotes precise objectives, steps and functions (Rodriguez, 2011). Contradictions that allow for a socially acceptable focus on autonomy, or individual responsibility, through pharmacologically based interventions and coercion in order to meet expected outcomes and goals such as medication adherence, are unavoidable in public sector community follow up models such as ACT (Rodriguez, 2011). Moreover, the author discusses how this focus on medication adherence can further isolate already marginalized people by individualizing social problems (p.48). The suggestion is that although standardized models of care might be necessary to improve access to public sector services, they might have the iatrogenic effect of uniformized care which does not lend itself to flexible services that can adapt to the needs of the service user and to the local context (p. 38-39). Applied to the ACT team, the standardization of ACT services across Québec will make intensive community mental health care more accessible to the populations that would benefit from this care, but there is a risk that the inherent flexibility of the ACT model is tempered by tensions in the process of uniformizing care.

The Québec experience

In Québec, ACT programs are referred to as *suivi intensif dans le milieu (SIM)* or intensive community follow up. For the purposes of this dissertation, ACT will be the program name that is utilized and this designation will include the SIM programs developed in Québec. This is acceptable because the Québec programs are modeled after the ACT programs initiated in the United States and elsewhere in Canada. Although ACT programs have close ties with the individual case management models (Bond et al., 2001; Goscha et al., 2012; Rapp, 1998; Rapp & Goscha, 2004) and are even considered to be a "specialized form of case management" (Burns, 2008), in Québec, literature from the CNESM distinguishes ACT from other case management programs (Rodriguez, 2011). This is due to the ACT model service design indicating that several service providers should intervene with the same service user in a transdisciplinary manner. Case management refers to care in which a single service provider offers assessment, intervention planning, referral and follow up within a system that has limited resources (Rapp & Goscha, 2004).[29] Similarly, Thomson et al. (2002) detail the

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[29] These authors note the perspectives of service users who claim that the term 'case management' is demeaning and exemplifies an unbalanced power dynamic as they are not 'cases' to be 'managed', but that for the moment it is the most globally recognized term that should be used with sensitivity. Saul Karsz (2004) discusses this in

functioning of a Québec ACT team in which each service user is assigned a main service provider and is supported by 2-3 other team members called the "mini-team".

In Québec, the new MHAP 2015-2020 highlights the importance of homogenizing the ACT service offer through the CNESM, which will measure fidelity to the ACT model. The CNESM will also support ACT teams in respecting clinical criteria and employing best practices (Government of Québec, 2015, p.54-55). The CNESM uses the TMACT scale to make sure the ACT teams conform to fidelity criteria (Monroe-Devitta et al., 2013). This evaluation tool includes a five-point scale on several items or indicators related to operations and structure. These include characteristics of the team and its functioning, the services offered, and adherence to criteria that are specific to ACT. A 2012 evaluation of the operationalization of the MHAP 2005-2010 indicated that within 5 years one-third (1/3) of ACT teams in Québec had to include a peer support professional[30] (Government of Québec, 2012, p.49). The MHAP 2015-2020 reinforces the previous policy by indicating that each ACT team has 1 psychiatrist, 1 specialist in employment and substance use, and 1 peer support professional (Government of Québec, 2015).

A 2012 evaluation of the MHAP 2005-2010 also indicates that despite efforts to standardize the ACT service design in Québec, the programs across regions in Québec are not homogenous and the service offer is variable (Government of Québec, 2012). This evaluation also noted that the RACOR, *Réseau alternative et communautaire des organismes en santé*

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depth, from a social work perspective, as the importance to take in *consideration* people's lives and experiences rather than to take *charge* of them.

[30] A peer support professional in Québec is an individual living with or having lived with mental health issues who has received formal training from the *Association Québecoise pour la Réadaptation Psychosociale* (AQRP) to become a mental health service provider whose role is to harness her experience and narrative of recovery in order to offer hope, positive identity, inspiration, and support to people who are also experience mental health issues (Repper & Carter, 2011). The MHAP 2015-2020 targets include having peer support professionals in 30% of variable intensity teams and in 80% of ACT teams (Government of Québec, 2015).

mentale d l'ile de Montréal, advised that it is necessary to encourage the development of mutual aid groups and foster the creation of social networks and community living in order to provide for the development of a quality of life in the community, appropriate and effective community based services, and a solid foundation for a process of mental health recovery. However, at the time of this research the CNESM did not consider group interventions or community capacity building initiatives to be part of the mandate of ACT.

1.2 Current state of affairs – strengths, limits and contradictions in ACT

Although many of the key features, or 'critical ingredients' of the ACT model as developed by Test and Stein (1976) and validated by fidelity scales continue to characterize most ACT teams (interdisciplinary model, assertive outreach, specialized and adapted case management model, service integration, low staff-service user ratio, 24hr/7 day a week coverage), some key ingredients are being modified as the ACT model evolves. An aspect of the traditional ACT program that has adapted to respond to organizational realities is the rigidity with which a program must adhere to the fidelity scales (Bond and Drake, 2015). For example, the idea of time-unlimited support is being challenged in an era of integrated services in which other community supports, such as variable intensity follow up and alternative community mental health organizations are recognized and more utilized. In addition, improving access to the ACT program, through increased ratios and discharges to less intensive programs is documented as an important concern for service providers who worry that service users' needs and experiences may not be adequately considered (Bromley et al., 2015).

Moreover, Rodriguez (2011) discusses essential aspects of practice in community support models, which should be upheld in order to create conditions for a high level of service quality. These include developing a trusting, voluntary relationship with the service user to support empowerment; awareness and understanding of the influence of the biomedical model in order to understand the limits of pharmacological treatments and the use of contention; integrating a flexible and intensive service offer; considering and intervening on both individual and collective dimensions; and developing mechanisms for full participation and active citizenship of service users in the organizations. In Estroff's (1981) seminal ethnographic account of an ACT team in Madison, Wisconsin, the perspective of the very people who were 'deinstitutionalized' into the ACT program was explored. Estroff's research challenged the mainstream notions of community care as a simple solution to psychiatric hospitalization. She unearthed paradoxes related to community based mental health care which demonstrated that service user freedom to circulate and develop varied social contacts was still very limited, albeit better than it would be inside hospital walls. She observed that the ACT team she studied contributed to the stabilization of service users "within the realm of negative differentness" (p.250). In other words, the objective of hospitalization avoidance was reached, but social integration and inclusion was still an elusive goal. The challenges and paradoxes outlined by Sue Estroff have not necessarily resulted in an improvement of care or quality of life for people living with serious mental illness in the community. As it is implied in her ethnographic methodology as well as by the results of more recent research outside of the US critiquing the ACT model (Burns et al., 2000; Gomory et al., 1999), a contextual overview of community mental health care is important in order to frame the development, purpose, practice, and role of ACT.

1.2.1 Strengths and Limits

A detailed review of the literature on ACT reveals both strengths and limitations of this model as a "leading model of community mental health services" (Bond and Drake, 2015, p. 241). Many of the 'critical ingredients' cited in the literature and first identified at the dawn of Assertive Community Treatment programs are still considered to be the strengths of this community follow up approach. These include the availability and accessibility of an interdisciplinary team that can offer a 'one stop shop' of services and treatments ranging from pharmacological treatments to psychosocial support. Since the mandate of a strong interdisciplinary team is so central to ACT, the role of the service provider within the team is actually independent of their professional base. Thus, the practitioner's role as a team member and not their profession will determine their actions[31] and possibly lead to less corporatism within the team (Thomson et al., 2002). An extensively studied and described feature of the ACT model (Bond et al., 2001; McGrew and Bond, 1995) is the low service user/service provider ratio which is in part credited for avoiding traumatic pathways to care through emergency room visits and hospitalizations and "improv[ing] residential outcomes" (Goscha et al., 2012).

Another documented strength of this program is the integral flexibility and mobility it offers to service providers in order to accompany service users in the community (Poirel, 2011). In other words, the ACT program is capable of evolving and responding to the needs of the vulnerable population that it serves. This may have a positive impact on both service

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[31] The literature on ACT programs demonstrates that the role professionals play on the team is independent of their professional base so their professional distinction not a pertinent factor. However, we acknowledge that this information is something that will also be validated through this research.

providers and service users. For example, the flexibility of the program is not only in the ability for services providers to offer time unlimited support, or frequent on-demand meetings with service users. The organizational structure of ACT is “endorsed …as a flexible service model that could be augmented with other evidence-based practice to address specific target populations” (Bond and Drake, 2015). This may include adapting the service to meet the needs of a marginalized population living in a situation of homelessness or to serve a population that has high rates of substance use. In a small study by McGrew et al. (2002) 44% of service user participants reported not disliking anything about their experience receiving services from an ACT program.[32]

Recent literature on ACT is now attempting to incorporate a strengths-based, recovery-oriented perspective (Bond & Drake, 2015; Salyers and Tsemberis, 2007) although Salyers et al. (2011) study of recovery-oriented approaches on two ACT teams indicates that “the impact of recovery orientation on consumers and staff remains to be seen” (p. 11).

Exploring the already documented parameters of ACT may help to determine a pathway to understanding the limits. Recurring themes regarding ACT boundaries include: limited changes in practice approaches and interventions; the biomedical bias in practice and research on ACT; coercive and controlling practices; and the professionalization of individual needs. In addition, the ACT model has demonstrated conflicting evidence in terms of service user improvements in certain domains such as social supports, quality of life, and sustainable housing. These recurring themes in the literature will be discussed in order to then explicate

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[32] These results, obtained from a service satisfaction interview questionnaire, are extracted from a larger study conducted from 1989-1992 on ACT programs in Indiana, USA. It is worthwhile to note that 21% of respondents also felt that the ACT program was too intrusive. This contradiction will be discussed below.

the contradictions and paradoxes in the ACT model.

The *Regroupement des ressources alternatives en santé mentale du Québec* (RRASMQ) has stated that changing the location of interventions (ie. Practicing in the community instead of in a hospital or clinic) is not sufficient to change the type of practice approaches that are used (RRASMQ, 1987a in Rodriguez et al., 2006, p.87). As explained by Stein (1989) in Davidson et al. (2009), care that is provided outside of hospital settings is community based care, not to be confused with the more complex community focused care. Community focused care includes values such as promoting the development of citizenship roles and connection with social roles in the community; finding meaning and purpose in life; working to fight stigma and increase access to a variety of resources, and developing a positive culture of healing (Davidson et al., 2009). Typically, a renewal or change in practice is articulated as a reconciliation with social or psychosocial concerns such as social connections, community living, or safe and secure housing, and a distancing from traditional symptom management. Persistent concerns have been expressed regarding the lack of transformations in practice despite a change in the location of care (Dorvil, 2005; Khoury & Rodriguez, 2015; Rodriguez, 2006, 2011) from inside the institution (read: hospital, asylum) to outside the institution (community). The objective of symptom reduction or effacement is so prevalent in the work of ACT professionals, that many clinicians feel uncomfortable discharging service users from ACT to a less intensive community mental health service (Bromley et al., 2015). The impact of this emphasis on symptom reduction in ACT programs as a central objective of the service to the detriment of other possible community mental health work is not yet fully understood.

As aforementioned, the ACT program was born out of the impetus to prevent hospitalization and to reinforce the public mental health sector in the aftermath of deinstitutionalization. The practice approach, “analogous to care in a hospital” (Drake and Burns, 1995), is essentially pharmacologically oriented. These practices include symptom reduction and home delivery of medications with a central role given to psychiatrists (Drake and Burns, 1995). Alternative mental health organizations and psychiatric survivor groups discuss the reductionist biomedical approach in terms of the practical irrelevance to service users’ lives (McCulloch et al., 2005, p.10). Since the 1970’s alternative mental health community organizations have contested the pervasive power of the reductionist biomedical model in psychiatry (Corin et al., 1996; Rodriguez, Corin & Poirel, 2001; Rodriguez, 2005) and pushed the field of mental health towards a paradigm shift that would consider other factors to achieving mental well being such as empowerment, agency, hope, decreased stigmatization, and full participation in society to create room for active citizenship. This includes questioning the power imbalances that may exist between the service user and the mental health practitioner. It is related to another documented limit of the ACT model, namely the persistent concerns that an ACT team may engage in coercive practices and participate in surveillance and social control mechanisms (Dorvil, 2005; Estroff, 1981; Gomory, 1999).

Latimer et al. (2010) acknowledge that coercion, which can encompass a wide spectrum of actions and behaviours, is often used in ACT as well as in psychiatry in general to ensure medication compliance and reduce missed appointments. This refers not only to medication management, but to financial and social management of service users as well. Regarding medication management, it is well documented that community mental health treatment in psychiatry is principally based on the administration of medication in the service users' community, specifically in their living environment (Gélinas, 2009; Poirel, 2011; Rodriguez, 2011). Deci et al (1995, p. 677) found that 80% of 303 ACT programs surveyed delivered medications. In fact, Thomson et al. (2002) and McGrew et al. (2003) state that the presence of nurses on the ACT interdisciplinary team is essential due to the central notion in the ACT program of pursuing psychiatric treatments (read: pharmacological treatments) in the community. In one study by McGrew et al. (2003), participants, who were service providers, rated medication management as their most beneficial clinical activity.

This non-exhaustive breakdown of control and coercion within the ACT program includes the role of financial and social management. Deci et al. (1995, p. 677) found that 82% of 303 ACT teams surveyed provided financial management for service users. Latimer et al. (2010) recognize that additional coercive actions on the part of an ACT service team may include restricting access to resources such as money. The limits and constraints related to social management stem from concerns that the assertive aspect of ACT is very intrusive and that it is a barrier to empowerment and choice. In the aforementioned analysis by McGrew et al. (2002) as part of a larger study on ACT, they asked service users what they liked least about ACT. Results indicate that 21% disliked specific features of the program such as home visits, which were related to intrusiveness and paternalism. There is also the concern of the normative and restrictive parameters of what is considered social functioning (namely employment, education, and sometimes volunteering) to which the ACT model is meant to respond. Employing an anthropological perspective, Corin (2002) determined that according to people with lived experience of serious mental health problems, the possibility to construct a place that is at once within society, but also on the margins of society is what helped them live and stay in their community. In this chosen marginal space, the individuals that participated in Corin's (2002) study felt that they could take the time to reconnect with themselves and take a personal journey at their own pace. How might service users embark on a personal recovery journey whilst maintaining an imposed schedule of visits and appointments?

1.2.2 Contradictions

These strengths and limits, which seem to be polarized items, are clear indications that a delicate balance is necessary. A community *focus* that is not simply community *based* implies that service providers assist service users in developing and maintaining natural support systems – and this may be through community building – so that service users may have a life of quality in their community. The development and strengthening of natural supports, or resources, through non-professional human contact, are not mentioned in studies of ACT.

As aforementioned, ACT has a history of coercive and intrusive interventions that are almost singly focused on pharmacological adherence in order to manage symptoms (Dorvil, 2005; Latimer et al., 2010; Rodriguez, 2011). One of the reasons why this is occurring may be found in the absence of a clearly articulated philosophy of practice in specialized psychiatric community mental health programs. Rodriguez et al. (2006) discuss research on practice approaches in alternative community mental health organizations in Québec, *"... certaines pratiques essentielles, au-delà de celles fondées sur la recherche expérimentale, font appel à des manières d'être, à des attitudes et à la capacité d'être en relation"* (p.149). This refers, in part to a consideration of the service users right to know about and then choose a path of service continuity. The notion is predicated on flexibility in both the clinical and administrative integration of services.[33] Rodriguez et al. (2002) explored how integration of services is achieved in different mental health contexts. Analysis of the discourses of services users and practitioners indicated that contexts in which services user are given the space to construct and integrate the services that are pertinent, places them in a central and active role. Thus, the question arises: Do ACT team professionals have the flexibility to construct practices based on relationship building rather than on specific interventions dictated by fidelity scales?

Finally, practicing in the community and in proximity to a person's living conditions offers a privileged space to meet and understand an individual's lived reality. Many people living in poverty or who are socially vulnerable and marginalized are overrepresented in psychiatry, possibly due to a psychiatric bias to over-pathologize some groups (Morrow & Weisser, 2012, p.29). Moreover, social and structural inequalities including social determinants of health[34] are likely to exacerbate difficult living conditions, thus impacting mental health. The literature does indicate that public mental health service providers can support services users (read: members of society) in becoming and maintaining equal citizenship status by analyzing power relations and structural inequalities (Morley and Macfarlane, 2010; Rowe and Pelletier, 2012). However, advocacy on the part of ACT case managers, which might confront systemic inequities that socio-economically marginalized and

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[33] This relies on interdependence between different service providers and external partners and an increased responsibility of service providers to ensure a continuity of care so that organizations are no longer working in a silo. Theoretically, when integration occurs at the clinical level various practice approaches and procedures are coordinated in order to ensure continuity of care and services for people living with mental health problems. This might concern integration with regards to individualized intervention plans, liaison, and case management. Integration is also meant to occur at the administrative level; mechanisms related to governance, management of resources, and evaluation of the system are aligned. At the administrative level this might concern integration with regards to coordination and strategic planning.

[34] These are defined as a person's conditions of life, both economic and social, that influence their health, mental health and well-being (Mikkonen & Raphael, 2010). The 1986 Ottawa Charter stated that political, economic, social, cultural, environmental, behavioural and biological factors can all impact health and mental health negatively or positively.

people often face, is also almost never mentioned in the ACT literature. Most of the literature is silent about the systemic impact of poverty and discrimination upon mental health service users and it is not at all addressed by the literature on ACT or best practice approaches in ACT. The ACT literature is silent on systemic problems and solutions that attend to the impact of social determinants of health, perhaps indicating that those pathways to care and intervention construction are marginalized in this program model.

This overview of the ACT program, its strengths, limits, and contradictions, gives us the possibility to explore and respond to a very specific context and concrete reality – that of an ACT program in an urban setting with a significant proportion of social and economic disadvantages. A solid understanding of the recovery philosophy as well as its inherent strengths, limits, and contradictions is presented in the following section to facilitate an explication of the connections and relationship between studying an urban ACT team in a recovery-oriented policy era.

Chapter 2 - Mental health recovery

Recovery is a polysemic concept that has been referred to as a vision (Anthony, 1993), a model (Jacobson & Greenley, 2001), an approach (Davidson et al., 2006), a paradigm (Carpenter, 2002) and a social movement (Resnick, Fontana, Lehman, & Rosenheck, 2005). Mental health recovery includes finding control over one's life, full participation in society and in treatment, and recognizing the singular experience of suffering that allows for the possibility to explore and transform one's relationship with oneself and with others at a rhythm and pace that is not predefined (Rodriguez et al., 2000; Corin, 2002; Provencher, 2002). More recently, dimensions of citizenship as they relate to mental health recovery have been articulated (Davidson et al., 2010; Rowe et al., 2012; Rowe and Pelletier, 2012; Ware et al., 2007). These have the potential to provide a critical reading of recovery in policy, practice, and rhetoric.

The 'recovery movement' in mental health has taken place against a backdrop of the negative consequences of the asylum model of care and of the tyranny of chronicity as a guiding perspective of mental illness. The pessimistic determinism of early psychiatric practice placed the 'mentally ill patient' in a cycle of hopelessness and helplessness with no real connection to society outside of the asylum. The recovery philosophy is fundamentally opposed to conceptualizing the experience of mental health problems as a chronic and degenerative process. However, the origins of this approach are multiple. Each source develops the concept of recovery from a particular angle.

The first derivative of a recovery idea or concept took hold in the 1970s and 1980s. The concept of recovery in policies in the United States, where the recovery nomenclature first emerged, was based on the results of longitudinal studies that illustrated how the majority of people living with serious mental health problems obtained their goals of autonomy and recovery and no longer needed to be ‘in the system’ (Harding, Brooks, Ashikaga, Strauss and Breier, 1987). As discussed by Farkas (1996) and Anthony et al. (2003) these studies were the empirical basis for this paradigm shift that was particularly influential for policy makers and for the institutional adoption of recovery. The longitudinal studies are typically entrenched in a positivist philosophy and aim to develop evidence-based practices. Within the framework of these longitudinal studies, the meaning of recovery seems to be conceptualized as a cure or the attainment of sufficient functioning to no longer require services. This ‘clinical’ definition of recovery that is also espoused by the aforementioned longitudinal studies (Harding et al., 1984) is reliant on outcome studies and places importance on the individual’s responsibility for his or her recovery. Psychiatric literature tends to describe recovery within the context of a biomedical approach stating that “complete recovery [is] the loss of psychotic symptoms and return to the pre-illness level of functioning” (Warner, 2010). Harding (1994) as cited in Jacobson and Curtis (2001) states that outcome signifies the end of a journey; this is in contrast to the service user narratives that have helped to conceptualize recovery as a never-ending process that ebbs and flows, as a process, a journey, and/or the fulfillment of a life project.

In the 1990s, in an attempt to resist the prevailing logic of poor prognosis for people living with serious mental health problems, the concept of recovery was a driving force behind changes in the clinical vision of mental health services in psychiatric rehabilitation (Anthony, 1993). With his 1993 article *Recovery from Mental Illness: The guiding vision of the mental health service system in the 1990's*, William Anthony foretold of recovery-oriented systems even in institutional settings. He described this new philosophy as one whose values include process-oriented person-centered services, a move away from the disease model of care, service user involvement, shared decision making, development of citizenship and social roles, empowerment, connection with social roles, finding purpose and meaning in life, hope, human rights and a positive culture of healing (Anthony, 2000; Chamberlin, 1998; Deegan, 1997; Farkas, 1996; Jacobson and Greenley, 2001; Jacobson and Curtis, 2000; O'Connell et al., 2005). One of the most widely cited descriptions of recovery from a psychiatric professional is the following:

> "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life" (Anthony, 1993, 527).

Accounts of recovery were used to build practice models for use in psychosocial rehabilitation services that were aligned with the concepts of empowerment and recovery (Farkas, 1996). During that period, Farkas and Vallée (1996) stated that recovery is the goal of rehabilitation (p.1) although they lament the fact that empowerment discourse was not well translated into practice or policy. Empowerment refers to an individual having control over his life and active participation in the decisions that are made that affect his life (Government of Québec, 1998). It also refers to the space given to exercise freedom of choice based on informed consent (Rodriguez et al., 2006). Corin and Harnois (1991) in Rodriguez et al. (2002) discuss the importance for practitioners to begin with the needs of the service user whilst planning interventions that take into consideration their attitudes, values, and the meaning they attribute to their experience. Provencher (2002) also speaks to the importance of relationships and empowerment when discussing subjective service user perspectives of recovery approaches as supporting an individual in redefining one's identity, one's relationship with others and empowerment. Authors such as Jacobson and Curtis (2000), refer to being in recovery as a "manifestation of empowerment" (p. 334). In the 1990's, whilst the concept of recovery was gaining terrain in the literature, 'empowerment' was being conceptualized. The term *empowerment* had already become a "popular term in mental health programs" (Chamberlin, 1997, p.43) as evidenced in Quebec's *Plan d'action pour la transformation des services en santé mentale* (1998). Manning (1999) discusses empowerment as a model that "reflects the consumer voice" (p.102) and rebalances the distribution of power between the mental health service user and the mental health practitioner. Manning, Zibalese-Crawford and Downey (1994) developed a study (as cited in Manning, 1999) consisting of 11 group interviews with service users and their families as well as 17 individual interviews and participant observation. Their research led to the identification of major themes of empowerment: self-determination, decision-making, information, respect, involvement, contributing to others, and 'coming out' (p.106). In an effort to develop a working definition of empowerment, Judy Chamberlin (1997) directed a research project in which she created an Advisory Board of consumer/survivor self-help practitioners. Together they defined empowerment as having 15 qualities, which echo the findings of Manning et al. (1994). Chamberlin (1997) also briefly discusses the importance of evaluating empowerment outcomes in the context of psychosocial rehabilitation programs that claim to advance elements found in the working definition of empowerment (p.46).

The potentially transformative and revolutionary underpinnings of the recovery movement resulted in optimism for a renewal of practice or the development of innovative practices parallel to mental health policy reforms (Davidson, Tondora et al., 2009; Davidson, Drake et al., 2009). Before turning to the challenges and paradoxes related to implementing a recovery-oriented approach within an ACT team, the next section will continue to explore discursive notions of recovery, particularly as elaborated by service providers, practitioners, and researchers. Recovery practice seems to be based on values and attitudes that emerge in practice. Only recently have these approaches and practices become the object of research efforts. Their effects have been documented in scientific and clinical literature and through the narratives of service users. I will examine the development of recovery-oriented practice in a step-by-step manner, beginning with the philosophical basis of recovery. I will then review the varied conceptual models of recovery. I will outline essential services that are born out of the values and dimensions of recovery and finally the approaches that have thus far been rubber-stamped as synergetic with recovery values, dimensions, services, and approaches. I will then review gaps between recovery discourse and recovery practice particularly in terms of service user notions of recovery. This section will conclude with an overview of critiques of the recovery concept.

2.1 Recovery: from concept to practice

Recovery is a term that has been discussed and debated in North American mental health literature for almost two decades. Yet a consensus on what recovery actually represents, a model, a philosophy, a paradigm shift, a program, or an intervention strategy, has not emerged; it remains a contested concept. As discussed by Jacobson (2004), the meaning of recovery varies according to the positionality of the individual or group and according to the context. In her book *In Recovery: The making of mental health policy* she outlines different meanings of recovery that are held by the various promoters of this orientation in mental health care. Davidson et al. (2006) report that it is the heterogeneity of the recovery experience that makes it complex to use for policy. Ralph (2000) and Davidson et al. (2006) reiterate Jacobson's assertion that the definition of recovery is heterogeneous; the context in which it is defined has profound implications for the meaning that it carries. However, the heterogeneity of recovery is not inherently negative; some authors believe that a homogenous definition could stifle critical reflection (Corin et al., 1996; Rodriguez et al., 2000).

2.1.1 A conceptual exploration

Farkas, Gagne, Anthony & Chamberlin (2005) identify core values of recovery and believe that recovery-oriented practice is based on a "person orientation or a focus on people, with talents, strengths, aspirations, and the full human experience; partnership or full involvement of individuals in all aspects of our work; choice or self determination; hope or a belief in the inherent possibility of growth". These orientations of recovery are transversal in the literature (Anthony, 2000; Chamberlin, 1998; Deegan, 1998; Farkas, 1996; Jacobson and Greenley, 2001; Jacobson and Curtis, 2000; O'Connell, Tondora, Croog, Evans, & Davidson, 2005). Various authors posit that although an individual will go through the process of recovery, professional intervention can facilitate this process (Anthony, 1993, 2000; Davidson et al., 2006; Rodriguez et al., 2000; Rodriguez et al., 2006).[35] This requires certain "critical

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[35] Farkas (1996) states that although service users go through recovery, she distinguishes the role of rehabilitation services as, "[the] process by which practitioners facilitate recovery…focus[ing] on people regaining valued roles in their communities so that they have success and satisfaction" (p.6). Deegan (1988) also makes a similar distinction between rehabilitation and recovery; she describes the former as the services that are available and the latter as part of life experience. More recently, Davidson et al. (2006) have made the distinction between

values underlying our practices...‘people first’ values” (Anthony, 2000, p.105). These philosophical assumptions underlying recovery have served, in part, as the basis for developing conceptual models of recovery. Anthony (1993, 2000), Slade (2010), and many other authors place values at the crux of the development of a mental health recovery model.

One of the uses of the recovery perspective, primarily from service users and “disaffected professionals” (Pilgrim, 2009) is as a critique of the biomedical hegemony that pervades mental health care and the iatrogenic effects of medication. Service users such as Chamberlin (1978) and Deegan (1988) have worked closely with social psychiatrists and psychiatric rehabilitation researchers and practitioners to develop conceptual models and explanations of recovery. Deegan’s (1988) often cited explanation of recovery states:

> “Recovery refers to the lived or real life experience of people as they accept and overcome the challenge of the disability…they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability.” (p.7)

Service user narratives tell us that mental health recovery is a journey and not a mission to return to a pre-symptom state of being (Deegan, 1997; Mead & Copeland, 2000; Ridgway, 2001); it is about the subjective articulation, interpretation, and integration of an experience into one’s self-identity and life path. This journey and constant evolution of self often involves family, friends, peers, and mental health professionals. The perspective of service users is essential in order to understand the participative and collaborative philosophical underpinnings of the mental health recovery orientation. First person accounts of recovery in mental health have been documented for decades and some psychiatric survivors

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recovery-oriented care and recovery; they describe the former as the role and responsibility of the mental health care provider and the latter as the role and responsibility of the service user.

are well known in the literature for sharing their narratives. These accounts often discuss reconstructing one's identity following the historic and oppressive socialization of their role as mental patients and the trauma of being labelled as mentally ill. This refers not only to the long period in psychiatry in which many people were institutionalized for living with mental health problems, but also to contemporary mental health practice wherein service users continue to be reduced to the descriptions of their diagnosis and their behaviours as observed by others, their 'symptoms'.[36] The recovery perspective also includes a repositioning of the person as a citizen and as a human being with worth and dignity.

In 2002, Ellen Corin wrote an article on the possible meaning of recovery from the perspective of people having experienced psychosis. The article reiterates a phenomenon dubbed "positive social withdrawal" (Corin & Lauzon, 1996; author's translation) which emphasizes a post-psychosis state of recovery that is entrenched in a subjective and deeply personal understanding of one's social relationships and oneself. The inherently intimate and tolerant experience of recovery described by Corin & Lauzon (1996), which includes respecting a person's right to be alone and withdrawn from society belies a more mainstream, normative belief that recovery is only possible through the attainment of certain normative accomplishments. Patricia Deegan (1993) is the first of many service users to articulate in the literature that it is important to understand that people who have experienced severe mental health difficulties are recovering not just from the specific symptoms related to those difficulties but also recovering from the iatrogenic effects of the problems such as stigma, labelling, exclusion, and side effects of medication. However, the push in policy, practice, and even in society for inclusion and recovery through employment, training or education saturates

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[36] For more information on these phenomenon see Goffman (1968) and Barrett (1996)

the objectives of the ACT program as per the literature. How can this be understood within a program structure that requires service providers to engage in intrusive and frequent interactions and interventions? What are service provider and service user perceptions of this potential paradox?

There has been significant work done to circumscribe recovery from the perspective of service users via narrative interviews that spotlight their unique experiences and life trajectories. The participants in these studies (Ridgway, 2001; Jacobson & Curtis, 2001; Mead and Copeland, 2000) give a voice to a group, although heterogeneous, that has been historically excluded, stigmatized, and marginalized in mental health research and practice. The conclusions indicate that there is a type of therapeutic relationship, new to traditional service delivery settings, but perhaps already in place in alternative mental health settings, that might foster recovery. This relationship is characterized by mutual support, empowerment, and partnership. Ridgway (2001) set out to determine whether common patterns exist within the lived experience of recovery in individuals (p.336) and to contribute to a more complete conceptual understanding of recovery. She examined user testimonials from before the 1990's (Deegan, 1988; Leete, 1989; Lovejoy, 1982; Unzicker, 1989). Using grounded theory to determine the critical concepts found in recovery, the first person narratives were analyzed using a constant comparison methodology. Her work exposed a core narrative of a shift in the lives of these 4 individuals from feeling trapped in chronic disability and relegated to a stagnant life situation to a much more complex and dynamic life story that was best understood as a unique ongoing journey (p. 337). Common recovery themes included: the reawakening of hope after despair, breaking through denial and achieving understanding and acceptance, moving from withdrawal to engagement and active participation in life, active coping rather than passive adjustment, moving from alienation to a sense of meaning and purpose, a complex non-linear journey that involves support, and partnership. This position of partnership, Ridgway concludes, is an essential location for practitioners in order to facilitate recovery. Another analysis of service user narratives comes from Jacobson and Greenley (2001) wherein the participants described recovery as a journey. Like Ridgway (2001) the authors were interested in developing a conceptual model of recovery in order to move forward in developing recovery-oriented services in the State of Wisconsin. Their analysis determined internal and external conditions that together contributed to the process of recovery. Internal conditions included hope, healing, empowerment, and connection. External conditions included an implementation of the principles of human rights, a positive culture of healing and recovery-oriented services. Finally, an article by Mead and Copeland (2000), who are self-described as “consumer leaders” (p. 315) and are executive directors of a peer support centre in the United States explain the meaning and significance of recovery from their own experiences. They list the key facets of recovery as hope, individual responsibility for wellness, education, self-advocacy, and peer support. They conclude by citing the need for mutual support in clinical mental health service settings and discuss the importance of choice and self-responsibility with regards to medication.

In Québec, Rodriguez et al. (2000) conducted a research project that studied the lived experiences of people who frequent alternative mental health resources. Their objectives included evaluating and questioning practices in those settings from the perspective of the service users. Although the authors did not directly employ the term recovery, this qualitative study evaluated the quality of services and practices in the alternative mental health settings by investigating concepts that are found in the discourse and literature on recovery. These include: hope, life trajectory, subjective experience of suffering and what this means, and service user perspectives. The 60 service user narratives that were analyzed in this study reveal deeply personal and unique experiences that do not necessarily fit into the descriptions proposed by psychiatry or traditional mental health practice models. The narratives revealed four ways in which practice can foster positive change within the service user: 1) by allowing for increased latitude and flexibility in describing an experience of suffering; 2) by giving the service user the appropriate time to work on himself and work through his personal history; 3) by reconfiguring interpersonal relationships; 4) by allowing service users to take their place in both social and cultural spheres – at their own pace and in their own timeframe (p.91-92). This study of service user narratives in settings that provide alternative mental health services and practice reveals the importance of taking the time to simply listen, but more poignantly it reveals the necessity for a larger, less medicalized definition of what constitutes a therapeutic relationship.

Whitley and Drake (2010) suggest that two of the most widely cited conceptual works by Davidson and Roe (2007) and Jacobson and Greenley (2001) have contributed to the development of person-centred care programs including supported housing and employment and peer support (p.1248). These dimensional approaches refer to recovery ‘in’ (developing social roles despite illness) and recovery ‘from’ (symptom based remission) and also refer to external versus internal processes of recovery. Many authors with differing conceptions of recovery agree that it is a process in which a person with mental health problems can recover without necessarily requiring professional intervention (Anthony, 2000; Davidson, 2009; O'Connell et al., 2005) thus placing importance on the individual's responsibility for his or her recovery journey. Paradoxically, this might be intertwined with results-based management models so that the operationalization of a recovery-oriented service is one that emphasizes short term follow ups, refusing treatment to people who do not show up to appointments (individual responsibility), and approaching each service user in a homogenous way. Recovery 'in' has been critiqued for focusing practice on individualized neoliberal principles of responsibility and self-determination coupled with person-centred professional support in order to have a normal meaningful life. Poole (2011) argues that this, as well as the dimension of recovery 'from' which is being used to develop quantifiable measures of the concept (Drake et al., 2015; Whitley & Drake, 2010) maintain the expertise and authority of psychiatry and professionals.

Anthony (2000, p.161) outlined essential services needed in a recovery-oriented system as going beyond traditional activities of treatment, crisis intervention, case management, and rehabilitation to include activities that enrich lives, include rights protection and self-development, self-help, and wellness/prevention. He then examined certain characteristics or "recovery system standard dimensions" (Anthony, 2000, p.163) that can be used to identify a recovery-oriented system. These include but are not limited to: a mission statement that describes recovery as the driving vision, seeking service user and family perspectives for evaluations (rather than relying solely on measured outcomes), and leaders who reinforce recovery. He points out that "a number of systems are declaring the development of a recovery-oriented system to be their intent" (p.159). However, structural barriers to this development were underscored; Anthony (2000) asserted that fragmented systems that do not help users connect with community resources cannot promote recovery.

2.1.2 From concept and services to practices and approaches

Since the 1990’s discursive practice and scientific research point to a ‘reconstruction’ of mental health practice that embodies the values and principles of recovery. However, several authors discuss the problems in implementing recovery-oriented services and practices due to the expansiveness of the concept and other barriers. Rodriguez et al. (2006) and Khoury & Rodriguez (2015) caution against confusing a transformation of services, as we are witnessing in Québec in the years following the MHAP, with transformations in practice. I will review two related practice approaches that are often used interchangeably when talking about recovery-oriented practice. I will then outline specific research and literature discussing how to practice in a recovery-oriented way.

Strengths-based and empowerment approaches

Rapp (1998) developed the strengths-based model and discusses case management with people suffering from severe and persistent mental illness. His conceptualization proposed a radical shift: moving the focus on illness or deficit to the background and instead focusing on strengths or resilience as the most effective path to recovery. The strengths-based approach aims to equip service providers in supporting service users in attaining goals beyond the basic necessities for survival. These include vocation, housing, and education, but also access to and satisfactory connection with leisure and arts activities. The guiding principles of this model and approach also include valorizing the community as a place of significant resources and recognizing that people are influenced by their environment and the resources to which they have access. Many mental health services and programs are currently using Rapp’s

(1998) strengths-based model for case management - or an adapted version of it - as a way to bridge the gap between recovery rhetoric and practice. The term recovery-oriented practice is sometimes used interchangeably with strengths-based practice. It is imperative however to maintain a critical stance of this trend regardless of its current following. The strengths-based model in the context of neoliberal organizational paradigms cannot contest reductionist perspectives focused on individual and family responsibility or self help which can mask problems that are due to structural inequalities and maintain the professionalization of individual needs (Gray, 2011). Many people living with mental health problems often site poverty, housing, marginalization, violence, and other personal and socio-political conditions as factors in their mental ill-health (Corin et al., 1996; Perron, 2005). Recent recovery literature also indicates that these social determinants of health that shape people's lives must be addressed (Davidson et al., 2001; Rowe and Pelletier, 2012) in a more explicit way. Moreover research shows that these social and economic conditions can be more important than lifestyle choices in influencing health (Mikkonen and Raphael, 2010). The growing usage of citizenship and recovery (Davidson et al., 2010; Pelletier & Davidson, 2009; Rowe & Pelletier, 2012) in the literature is perhaps a starting point for understanding how actors in public community mental health services such as the ACT program support marginalized members of society, such as service users, in contributing to a life of quality in the community and to reconnecting with their community or social network, if desired.

Recovery-oriented practice guidelines

Davidson, Tondora, Lawless, O'Connell and Rowe (2009) offer tools and guides to develop recovery-oriented practice. They describe a recovery-oriented care system as including diagnosis and symptom reduction in addition to promoting meaningful participation of service users, providing a wide range of services, building trust with service users, ensuring accessibility and continuity of care, accompanying service users in connecting with their local community, and using a strengths-based, collaborative, person-centred approach. More provocatively, and without directly discussing the recovery perspective, the book *Repenser la qualité des services en santé mentale dans la communauté: Changer de perspective* discusses service user satisfaction of interactions with service providers of a community support team. The authors (Rodriguez et al., 2006) were concerned with transforming practice approaches, and not just services, through research methods that allowed for a closer proximity to what is truly meaningful and impactful for service users. This means that they investigated results and outcomes that were significant for service users. Three transversal quality indicators are discussed that cut through any specific practice approach and go beyond a technical application of interventions. The quality indicators include a) a meaningful relationship with the service provider, including attitudes and behaviours of the service provider; b) recognition of a multiplicity of experiences, including having space to describe and name an experience of suffering in various ways depending on the service users' point of view; c) considering the primordial place of the service users in treatment application, referring to increasing dialogue and exchange of information with regards to different treatments ranging from ECT to individual therapy.

The most recent recovery-oriented practice guidelines from Canada (MHCC, 2015) outline 6 dimensions of recovery practice that echo elements of the above research. These include creating a culture and language of hope; recognizing each person's uniqueness and subjective experience, recognizing the importance of social relationships and life context;

responding to diverse needs with culturally responsive and safe practices; working with First Nations, Inuit and Métis to acknowledge their cultures' longstanding value base of well-being, self-determination, and a strengths based approach; and understanding that recovery is about transforming services and systems through partnerships and through learning from experiential knowledge. Every dimension acknowledges the individual's uniqueness and right to self-determination in their journey towards recovery and well-being, whilst considering the socio-political-economic context in which that individual is living.

My master's research project focused on mental health social work practice and was informed, in part, by Karen Healy's (2005) work in *Social Work Theories in Context: Creating Frameworks for Practice*. She discusses how each social work practice interaction is unique as it includes a negotiation of both purpose and practice with service users, organizations, families, and society. In my master's research, participants felt that recovery might be the way for social workers to put words on something that is already done (Khoury, 2012). Nevertheless, there were fluctuations in the understanding of the term recovery and recovery-oriented practice. Social workers in this study constructed their understanding of recovery based on their practice contexts. These in turn guided them in identifying which types of interventions they should use and in how to proceed. Although participant discourse indicated an immediate alignment with the term recovery, deeper analysis revealed a bureaucratic definition of recovery, which might be considered the imprint of institutionalized practice (Khoury, 2012). In order to create change and accomplish the profession's mandate to be agents of change, it is vital that practitioners be able to read their institutional context and understand how it interacts with their professional context (Khoury and Rodriguez, 2015). If actual practice is constructed in an active and ongoing manner, often using theories or conceptual frameworks loosely and in relation to organizational contexts, then how do the above approaches and indicators emerge on the field?

Operationalizing recovery practices: Standardization and evidence based practice[37]

Jacobson (2004) and Davidson et al. (2009) review strategies from the United States for operationalizing and implementing recovery, including training on recovery, recognizing that service users and their families are critical stakeholders, implementing peer-run services, and stigma prevention programs. However, it is not known if these strategies are being applied in the day to day operations of specialized mental health services, such as ACT teams. Whitley, Ginerish, Lutz and Mueser (2009) contend that there is little research on the implementation of recovery practice in community mental health settings. In their qualitative study, certain "modules" (p.203) of an Illness Management and Recovery (IMR) Program were identified through content analysis. These modules, which ranged from setting an optimistic tone, to helping people define what recovery means to them to using medication effectively and even coping with stress, are referred to as psychosocial evidence based practices (EBP). Four factors emerged in this study as affecting implementation of these psychosocial EBP: leadership, organizational culture, training, and staff and supervision. These IMR best practices are now integrated into a training kit specifically designed for service providers in

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[37] Practices that must be rubber stamped via systematically collected proof that they provide the desired results are often referred to as evidence-based practice.

ACT programs (SAMHSA, 2010).[38] However, studies by Salyers et al. (2010, 2011) show inconclusive correlation between IMR implementation and 'outcomes'.

Since ACT is supported in policy partly because of its position as an evidence-based program, the issue of EBP is primordial. There have been attempts to provide an evidence-base for recovery in order to integrate it into current health care service delivery frameworks. Are evidence-based practices, based on objective measurable evidence, a good fit with a recovery orientation that "relies on first hand experiences as [being] an equally valid source of information" (Davidson et al., 2009, p.323)? Although Davidson et al.'s (2009) article entitled Oil and water or oil and vinegar? Evidence-based medicine meets recovery concludes with a call to work towards a complementary role between recovery, recovery-oriented practice, and evidence based medicine, their article also states that, according to service users, there are limited effects of pharmacological treatments in the reduction or elimination of symptoms in their recovery.

To date, there has been very little Canadian[39] or Québec research on the meaning of recovery or recovery-oriented practice in public mental health services that are targeted by recovery-oriented policy. We do not know how implementation efforts have affected practice in a concrete way in Québec. Moreover, the voice of not only service users but also of service providers in public mental health settings is missing in the relevant Canadian empirical literature, with of course a few exceptions (Piat et al., 2009; Poole, 2011). McCranie (2011) suggests that silence on the topic of recovery from psychiatric and psychological clinical

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[38] There are other examples of recovery measurement scales (Giffort, Schmook, Woody, Vollendorf, & Gervain. 1995; Campbell-Orde, T., Chamberlin, J., Carpenter, J. & Leff, H.S., 2005)

[39] Although there is a large research programme from the Mental Health 'Recovery' Study Working Group in Ontario, Canada that most recently, through community-based participatory action research, looked at the meaning that Toronto service users prescribe to the word recovery

journals may speak to a cleavage between research and practice that must be addressed. This cleavage may be in part due to the increasing obligation to employ evidence-based practices. As such, some authors are trying to reconfigure EBP to include experience-based evidence so that qualitative research can be used to determine ‘evidence’ of recovery (Anthony et al., 2003; Davidson et al., 2009; Whitley & Siantz, 2012) and tease out the practical dimensions of recovery-oriented practice.[40] Nevertheless, Anthony, Farkas & Rogers (2003) questioned the ability of evidence-based practice to apprehend the broad perspective that a recovery orientation intimates. In other words, administrative goals of cost efficiency and accountability that sustain the EBP culture might result in a uniformization of practice that is difficult to marry with a recovery orientation (Gray and MacDonald, 2006; Teghtsoonian, 2009).

Recovery perspectives initiated by service users were originally used or intended to provide alternatives or alternative practices to traditional mental health services (such as peer support, community organisations). There are documented concerns that evidence-based practice, including a reconfigured EBP that includes experience based knowledge, might lead to the development of a recovery model that stamps out alternative or creative practices (and even alternatives to mental health practice) thus developing expert driven prescriptions that continue to govern mental health practice and the mental health recovery journey. What leeway do ACT teams have to initiate and construct emerging practices that are not considered evidence-based?

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[40] The promotion of EBP is linked to both a biomedical hegemony in which only ‘pure’ sciences are capable of legitimizing interventions and a neoliberal political context that emphasizes cost-efficient and standardized practices. Although there is a need in our public health system to offer a standard of care that has been proven to be efficacious, EBP entrenched in a neoliberal welfare State may risk considering only positivist and modernist knowledge to be scientific, ignoring diverse sources of knowledge such as qualitative and experiential evidence. Some argue that this reductionist approach is simply inappropriate because it “represent[s] an unwelcome privileging of apolitical positivism” (Goldstein, 1992 as cited in Gray & MacDonald, 2006, p. 8).

2.2 Challenges and criticisms of recovery

The recovery approach is not without its critics (Coleman, 2004; Hopper, 2007; Morrow & Weisser, 2012; Pilgrim, 2008; Poole, 2011) who point out that it is difficult to operationalize within traditional organizational structures especially as it seems distanced from its initially emancipatory, activist roots. Service users such as Coleman (2004) believe that the medical community has appropriated recovery and erased its initial transformative and emancipatory notions. This may be due to the very different conceptualizations of the term recovery in the scientific, service user, and policy literature (Bellack, 2006; Jacobson, 2004). Other authors have enumerated "abuses" (Slade et al., 2014) of the concept of recovery and lack of effective service delivery transformation resulting in practices that are not process-oriented (Kidd et al., 2015). Pilgrim (2009) and Roe, Rudnick & Gill (2007), amongst others, discuss how recovery is at risk of becoming meaningless due to many misunderstandings of the term. McCranie (2011) cites Hopper (2007) who states that recovery is a "co-opted, near-toothless gospel of hope" (p.877). This is echoed by Jacobson & Curtis (2000) and Jacobson (2004) who are concerned that recovery practice alongside neoliberal policy reform and a reductionist biomedical hegemony could lead to services and practices that simply pay lip service to a concept that was initially transformative. These authors raise concerns that the 'individual recovery journey' can be perverted to provide a basis for cutting services and reducing available practice approaches. Results from my master's thesis, an exploratory study of social worker perceptions of recovery in Québec, indicate that context, specifically systemic constraints such as work organization and agency structures, are key, limiting factors to recovery-oriented practice (Khoury & Rodriguez, 2015).

Pilgrim (2009) points out that the understanding and significance of recovery is not universal amongst service users. For example, one of the few Canadian studies expounding the meaning of recovery from the perspectives of Canadian services users includes interviews with 54 service users across Canada (Piat, Sabetti & Couture, 2009). Results indicate that two predominant conceptualizations of recovery exist amongst service users. The medical conceptualization, that is improved mental health or a return to the 'old self', and the psychosocial conceptualization, that is improved well-being and an evolution toward a 'new self', were not mutually exclusive. In Québec, Poirel et al. (2015) explored the conceptions surrounding integration and inclusion in society of people living with severe and persistent mental health problems. Three principle visions of integration and inclusion were extrapolated from the testimonies of service users and service providers in both the public sector and the community mental health sector. The first vision is coherent with the dominant discourse in policy and points to the importance of supporting people living with mental health problems so that they may integrate into society through normative pathways, primarily through work. The second vision points to the limits within this first dominant discourse, without offering an alternative. The third vision of integration and inclusion questions these concepts as potentially problematic and calls for a shift away from the dominant discourse. The implication in both Piat et al. (2009) and Poirel et al. (2015) research is that neither mental health service users nor service providers automatically prescribe to a specific narrative or conception of recovery. The research in Québec by Poirel et al. (2015) demonstrates the necessity to further explore the problematization of concepts such as inclusion and integration, that are so closely linked with mental health recovery. For example, social integration is often referred to as pertaining to 3 things: housing, employment, and education (Government of

Québec, 2012b; Poirel et al., 2015) excluding other important indicators such as volunteering and involvement in leisure and cultural activities. Pilgrim (2009) concludes that these contradictions result in various practical scenarios that embody differing conceptions of recovery.

On the other hand, some service users have become disgruntled by the recovery concept themselves, concurring with other research that it has become overly professionalized (Cheng et al., 2009). Morrow & Weisser (2012) specifically contest the professionalization of mental health recovery, with service providers becoming experts in recovery and thus maintaining historic, potentially oppressive power relations. Others suggest that the recovery model alone cannot fulfill its promise of developing meaningful relationships and projects with one's community of choice.[41] The principle tensions evoked by Pilgrim (2009), Coleman (2004), and Rogers et al. (1993) are between a practitioner perspective of recovery that often involves risk management, relapse prevention, and medication adherence and service user perspectives that typically point to positive risk-taking, autonomy, full citizenship, and a recognition of the iatrogenic consequences of psychiatric medication. There exists as well a body of work that explores the ethnocentric biases of recovery (Adenpole, Whitley and Kirmayer, 2013). Samples of user accounts in first person narratives research tend to be sourced from a homogenous group, namely a Western, English-speaking demographic. This limits the meanings attributed to diverse experiences of suffering, not all of which are included in a Western conceptualization of mental health or recovery. Transcultural psychiatric research has illustrated that there is a need to recognize the variations in the experience of mental illness and the meanings prescribed to it by different cultures (Manson and Kleinman, 1998).

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[41] For further reading refer to Inclusive Livable Communities for People with Psychiatric Disabilities (National Council on Disability, 2008)

Several authors have attempted to examine the recovery-orientation of ACT practices, especially since the model itself has been questioned for being coercive. Salyers & Tsemberis (2007) and Kidd et al. (2010) investigated how and if recovery is integrated into ACT teams. They examined commonly used indicators of how ACT teams operate. The conclusions indicate that these quantitative indicators cannot address the complex dimensions of recovery. In addition, the investigations did not consider the subjective meaning of the recovery journey for service users or how ACT services are experienced by the service users. More recently, Salyers et al. (2011) used a qualitative, interpretative approach to attempt to provide answers to the debate concerning the compatibility of recovery and ACT models.[42] Based on individual semi-structured interviews with service users and staff in two ACT teams they identified 4 critical components of a recovery-oriented ACT team: environment, team structure, staff attitudes (including views of consumers [sic], expectations, and language used), and processes of how ACT teams worked with consumers (sic). This study demonstrated that fidelity to the ACT model does not necessarily correlate with an alignment with a recovery orientation in practice. The authors mention that deeper, ethnographic research would allow for longer-term observations and that the scope of their study (focused on 2 ACT teams in Indiana, USA) was a limit. Moreoever, if mental health practice is a socially constructed and socially negotiated process then in psychiatry we are witness to a subjective interaction resulting in the application of an objective label (Furtos, 2007). Practically, this means although diagnostic tools are meant to provide a common language to service providers, the processes of making a diagnosis is a social and interactional one.

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[42] The long-term objectives of this study are to develop a qualitative recovery orientation measurement, akin to the more commonly used indicators of how ACT teams operate.

2.3 Practical concerns and contradictions in recovery-oriented community mental health care: challenge or opportunity?

Government mental health policies are creating and supporting community based mental health services that must also respond to a neoliberal economic paradigm of cost efficiencies and outcome measures. These services are also dominated by the social, legal and political legitimacy of traditional biomedical treatments that often focus on maintenance of normalcy for the purposes of social integration. Finally, these services are being asked to support recovery and recovery-oriented practices. How do theses contexts and structures shape the meaning of recovery and recovery-oriented practices? What types of actions and interactions are played out in a system that is meant to be simultaneously recovery-oriented, outcome focused, and biomedically influenced?

In light of the aforementioned tensions and paradoxes of service delivery in an ACT team during a ‘recovery’ era in mental health, the pertinence for research in public mental health settings that targets interventions and practice models that supposedly integrate a recovery vision becomes clear. We know from both the international and local Québec based research outlined above that a mental health practitioner’s role might include accompaniment of a person on his or her recovery journey. Despite empirical literature indicating ACT effectiveness in hospitalization reduction, symptom reduction, and increasing functioning (Bond et al., 2001; Latimer and Rabouin, 2011), little is known about the recovery orientation of ACT teams or the factors that may contribute to a recovery orientation.

Although the problem statement presented above highlights many challenges and obstacles to recovery-oriented mental health practice in a community based mental health team such as ACT, the description of ACT also illustrates how the program itself represents a privileged space to adapt to local contexts and to social interactions that in turn result in a local actualization of an ACT program. We do not have a clear idea about how mental health practitioners are able to implement, negotiate, and enrich their 'recovery-oriented' practice. This is perhaps due to the lack of consensus surrounding the recovery concept, the difficulties implementing recovery-oriented practice, and the lack of "practice-near" (Pilgrim, 2009) research on the subject. As discussed by Pilgrim (2009) empirical studies are only "scratching at the surface of recovery". Like Salyers et al. (2011), he posits that elements of ethnographic research are necessary in order to unearth the wide range of possible meanings of recovery so that practitioners may be informed by a plurality of perceived realities. As such, this dissertation adopts a research perspective, explicated in the following chapters, that proposes a repositioning of recovery practice in ACT team. This opens up the opportunity for an in-depth study of the interactions among professionals, service user, carers, and community members in a specific ACT team. The implication of adopting this type of research perspective is that the micro-level processes, ordinary dialogue, and interactions of all stakeholders that shape meaning on a daily basis will be explicated. At this micro-, interactional level, effects of the macro-level challenges such as poverty, inadequate housing, and inadequate access to health care are expected to filter down and impact the intersubjective interactions.

What is needed, and what this project proposes, is an empirical explication of mental health practice with a particular attention to recovery-oriented practice. This will provide practitioners and service users with a local, contextualised clarification of recovery-oriented practice as well as information that will allow for an understanding of how recovery is integrated into practice. This research study is original in 3 main ways. First, the body of empirical evidence on ACT teams is predominantly quantitative and usually concerns adhesion to fidelity scales. By privileging a qualitative methodology that allows me to be near to practice and favour a plurality of voices and perspectives. Secondly, this research will contribute to the advancement of knowledge and innovative practice approaches that are complex, locally situated, socially negotiated, and pertinent for both research and practice milieus as well as policy. Finally, this study will assist in dissipating ambiguities surrounding the concept of recovery and the practices in ACT teams, a cornerstone of the MHAP. Secondly, studies on the operationalization of recovery-oriented practice are inexistent. The only recent study on ACT conducted by Québec researchers (Latimer et al., 2010) was again quantitative and focused on measures of perceived coercion and client-centredness.

Recovery appeared in mental health policies in the United States, United Kingdom, and Australia (Bonney & Stickley, 2008; Ramon, Healy, & Renouf, 2007; SAMHSA, 2012) before being included in Québec policy in 2005 with the Mental Health Action Plan (MHAP) and in Canadian mental health strategy in 2009. The MHAP not only called for ACT services to be a cornerstone of community mental health care, it also officially recognized the concept of recovery as an orientation to develop practices focused on the whole person, hope, empowerment and active participation in society[43]. A few years later, in 2009, the Mental Health Commission of Canada (MHCC) published its framework for a Mental Health Strategy

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[43] "*La priorité qu'il faut accorder au rétablissement de la personne dans sa globalité et au développement de moyens qui lui donneront espoir et faciliteront sa participation active à la vie en société"* (Government of Québec, 2005a, p.11); *"Le plan d'action réaffirme la capacité des personnes de prendre le contrôle de leur vie et de participer activement à la vie en société"* (Government of Québec, 2005, p.12)

for Canada, which also called for recovery to be placed at the centre of mental health reform. In this document, recovery is referred to as a non-linear journey of risk taking, failure, and learning in which an individual living with mental health problems is able to establish a meaningful life in the community and be included as a valued member of society. The full citizenship that everyone must be accorded includes having the respect, rights, and entitlements, and opportunities as any other member of society in Canada (MHCC, 2009, p. 22). In order to do this, the MHCC states:

> "Restraint and coercion represent the ultimate loss of control….a principle of recovery-oriented mental health policy and legislation must be to always employ the least intrusive and least restrictive interventions possible" (2009, p.30).

With this statement in mind, one key, summary question emerges. This question seeks to unpack the ways in which the structure, approach, and characteristics of ACT programs support and promote recovery and recovery-oriented practices. What kind of recovery orientation is understood and accomplished in a specialized community based mental health team that is documented as regularly using coercive practices in order to reach the program objectives of hospital avoidance?

Part 2 - Research Design

The second part of this manuscript consists of two chapters that will outline the ontological and epistemological assumptions as well as the theoretical perspectives, methodology, and methods from which the daily construction of community mental health practice is being studied. The first chapter will serve as the foundation to understanding and defending the selected methods of data collection and analysis. The selection of research design, from the ontological and epistemological assumptions to the methodological question, are based on several aspects of scientific inquiry. These include the presenting issue or concern (elaborated in Part 1), how the researcher sees the world, and finally how the researcher views the possibility of a relationship with the world, including a relationship with the object of study. Creswell (1998) refers to this as a researcher's 'worldview', whilst Guba and Lincoln (1994) call the ontological, epistemological, and methodological underpinnings of scientific inquiry a 'paradigm'. In a similar vein, Crotty (1998) developed a knowledge framework, which frames the research process by epistemology, theoretical perspective, methodology, and methods. The first chapter of Part 2 will refer primarily to Guba and Lincoln's (1994) paradigm of scientific inquiry and Crotty's (1998) framework in order to outline the broad assumptions and detailed research actions that guide this study.

Chapter 3: Theoretical perspectives – combining paradigms for a critical constructionist approach

3.1 The ontological and epistemological posture

According to Firestone (1990), paradigms can be combined or "accommodated" (p.105) and result in "cross-paradigm research [that is] extremely fruitful" (p.109) especially if the relationship between research principles and research practice is viewed as dialectical. Guba and Lincoln (1994) also state that paradigms are human constructions and no single construction of a paradigm is 'right' in absolute terms.[44]

For Guba and Lincoln (1994), the fundamental questions surrounding the ontological and epistemological posture of the researcher and the inquiry must be answered before articulating the methodological posture. Their first question (ontological) asks 'what is the form and nature of reality and what can be known about it'. Their second fundamental question concerning epistemology can only be answered in light of the ontological question and seeks to know 'what is the nature of the relationship between the knower and what can be known'. Finally, the methodological question asks 'how the knower can go about finding out what she believes can be known'. However, before elaborating the 'methodological question' I will insert Crotty's (1998) knowledge framework, which relies on a discussion of theoretical

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[44] As a social worker, I have first hand experience with a practice field that combines practice approaches from different paradigms in order to avoid reductionism and tokenism; combining practice approaches can help promote choice in intervention planning for the service user. Parallel to this professional experience, as a researcher I strongly believe in the contribution that social work as an academic field can have through its pluralistic lens.

perspective before delving into the chosen methodology and methods. As such, this chapter will review the ontological and epistemological questions and the theoretical frameworks guiding this study. In Chapter 4, I will explicate the specific methods of inquiry as well as the analytical strategy.

3.1.1 The ontological question

My worldview aligns with the ontological worldview of critical theorists who see reality as an accumulation of structural and historical insights shaped over time (Guba and Lincoln, 1994). However, the idea that knowledge and reality are constructed through dynamic social interactions with others to create shared understandings is also fundamental to the theoretical positioning and framework of this research project. With a constructivist ontology, multiple views of a particular reality can emerge and they are local, alterable, and contrast strongly with the atemporal and universal knowledge claims and models of the positivist ontological positions wherein an apprehendable reality is assumed to exist. In the classic approach of constructivism the understanding of social actions is fundamental (Berger and Luckman, 1966). However, that worldview does not offer the opportunity to move beyond the creation of knowledge through social interactions toward the assumption that knowledge is value mediated and value dependent. In other words, the constructivist paradigm is useful in that it offers an understanding of the processes at play in the production of reality, however there is little influence in the potential to undermine the accepted scientific expertise and celebrate different kinds of knowledge from different kinds of people. For example, Beresford et al.'s (2010) report concluded that the medical model in mental health continues to be seen as very powerful among professionals, society, and service users. This is an important and revelatory finding, however it does not provide a call to action to overturn the singularly legitimizing force in mental health policy, practice, and structures.

A critical theory ontology offers the possibility to consider how “reality is shaped over time by social, political, cultural, economic, ethnic, and gender factors and then crystallized into a series of structures that are now…immutable” (Guba and Lincoln, 1994, p.110). Reality is often objectified, crystallized, and legitimized by media, politics, and groups in power; thus there is a risk that those in power might reappropriate (advertantly or inadvertantly) the positions of the ‘other’ to create new social policies, interventions, and even institutions that continue to serve their dominant perspective. The constructivist paradigm acknowledges a dialectical relationship between an individual and these external forces (Berger and Luckman, 1966; Guba and Lincoln, 1994) to ensure that those in power have a better understanding of other, more marginalized, realities (Firestone, 1990). However, I believe that it can be complemented by a critical paradigm in order to consider the power or strength of these external forces. The use of a combination of both a critical ontological perspective and a constructivist ontological perspective position, a “critical constructionism”, underscores the relationship between local forms of understanding and dominant societal values and ideology.

3.1.2 The epistemological question

As discussed by Carter and Little (2007) “epistemology is axiology” (p.1323) in that it is born out of a personal value base that influences how a researcher justifies knowledge. Although uncommon in the social sciences, it is not at all illogical or unthinkable to combine both a constructivist and critical tradition (Firestone, 1990; Jorgensen and Phillips, 2002).[45] Both paradigms embrace transactional and subjectivist epistemologies and dialectical methodologies (Guba and Lincoln, 1994). In a constructivist epistemological paradigm, meanings are inter-subjectively constructed through social interactions that are interpreted based on people's historical and social perspectives (Crotty, 1998 in Creswell, 2014). A critical epistemological paradigm helps to bridge the gap between values and social facts (which are treated as separate phenomenon in the purely constructivist paradigm). This is relevant for this research project, because I am seeking to not only understand local, context-specific constructions of practice, but also question the dominant system's influence on these local, specific constructions. This research project takes into consideration power inequalities in the ability for different actors to define, legitimatize, and reproduce reality and develop "action agendas to help marginalized peoples" (Crotty, 1998 in Creswell, 2014*)*. Social relations dependent upon material reality are also shaped by an ongoing and constant struggle to define that reality. Thus by employing a critical constructivist epistemology my research considers service providers and service users in an interactional stance with the local context and circumstances, but also as potential co-constructors of that context and circumstances.

In order for me to tackle the effects of my own knowledge production as a researcher and in order for my research to contribute to social change I combine critical and constructivist paradigms with the objective of unearthing the common sense notions, of "unmasking of dominant, taken-for-granted understandings of reality" (Jorgensen and Philips, 2002). As stated by Glasby and Beresford (2006) in a commentary in *Critical Social Policy* "the practice wisdom of health and social care practitioners and the lived experience of service

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[45] It is a tradition found in the field of critical education studies (Kincheloe, 2005) based on the work of both Frankfurt school critical theorists and of Pablo Freire's critical pedagogy.

users can be just as valid a way of knowing the world…" (p.268) as positivist, traditional evidence based research. Social structures have their origins in social actions and interactions; these social structures can be divisive and fragment social relations of those inside the structures. By recognizing the socially constructed nature of understanding (where realism is locally and specifically constructed) new alternatives for change and emerging practices can be generated.

The pluralism inherent in the social work discipline supports my personal accommodation regarding the epistemological question of "how does knowledge accumulate" (Guba and Lincoln, 1994, p. 113) and includes combining a practical interest in how people derive meaning from the social order that they create themselves and how they are impacted by the power structures in society in order to produce more informed insights and eventually action. The results of this combination is a personal construction of recovery, elaborated at the end of this chapter, that has been an overarching influence in both my practice and research.

In short, a critical constructivist ontological position considers the influence of socio-historical dynamics on the object of inquiry, in this case recovery-oriented community based mental health practice, as relevant to understanding the very object of inquiry. The critical constructivist epistemological position attends to an exploration of the foundations of what we know about recovery-oriented community based mental health practice.

3.2 Theoretical framework

I am interested in exploring the perspectives of various actors regarding their understanding(s) of recovery, of how recovery-oriented practice is produced, and of their understanding of the complex processes and interactions related to extreme marginalization and exclusion. This study is guided and informed by three theoretical lenses consistent with a critical constructionist epistemology. What follows is an outline of critical practice theory and ethnomethodology, specifically as they have been appropriated by social work and thus the discussion is mostly informed, and limited, by its use in social work tradition. In addition, both critical practice theory and ethnomethodology are integrated into an overarching framework of framing theory (Goffman, 1974) to understand the phenomena of the rules, values, and contextual interpretations that result in specific concrete practices and discourses. My critical posture is inextricably tied to a reading of recovery in which citizenship becomes a guiding conceptual framework, that will allow for an explication of the role of citizenship within the recovery approach as well as a posture that questions the dominant biomedical and neoliberal ideologies shaping our lives in general and our community mental health programs specifically.

3.2.1 Combining theories to access a complete picture: Critical practice theory and ethnomethodology

Critical practice theory

Part of "critique" is the questioning of knowledge production and what constitutes knowledge by challenging the "taken for granted" assumptions and practices (Foucault, 1978; Gramsci, 1971; Jorgensen and Philips, 2002). Foucault's critique of modern society is so total that Devine (1999) posits that he would "equate all…incarnations of Western institutions….as deceptively promising reform, progress, or freedom but in actuality delivering subjugation." (p. 251). Gramsci (1971) theorizes that hegemony is achieved when the dominant group's perspective is taken for granted as universal and natural. The dominant group must therefore exert not only physical power but also "moral and intellectual leadership" (Gramsci 1971, pp. 57-58). In mental health and psychiatry, this idea is elaborated by Foucault (1972) in his book History of Madness wherein he discusses psychiatric hospitals as "instances of order" (p.61) in which hospitals hold not only medical power, but also administrative and legal power. He explains that it results in the power of a dominant group to create a specific order, or hegemony. In his book Asylums, Goffman (1961) referred to the "total institution" which also speaks to control by a dominant group through social interactions that occur in a closed system, such as psychiatric hospitals. The legitimacy of our institutions and systems as socially constructed can be questioned when we consider the added measure of complexity introduced by the notion of "common sense" (Gramsci, 1971, p.199). This notion of common sense refers to a traditional and even taken-for-granted conception of the world. One of Gramsci's contributions is identifying this process in which consent from society is generated for interests that are not necessarily in their favour. Common sense is thus vital to the establishment and maintenance of hegemony and of legitimizing structures. Gramsci (1971) nuances the power of ideology by explaining it as a given set of practices within a social group in a given society, thus moving beyond a one-dimensional or instrumentalist approach. This idea is important for understanding how policies and mental health practices contribute to the hegemony of a dominant social order, such as a reductionist biomedical perspective and neoliberal capitalism, but also for constructing a strategy with which to challenge it - what Gramsci calls a counter-hegemony.

One of the critiques of critical theory is that it is not easily translated into practice, which is typically complex, uncertain, and contextually situated. Healy (2001) reiterates Wise's (1990) statement that critical theory does not do enough to unravel the complex nature of the practitioner's role and daily actions nor does it tell us how service users experience their relationship with practitioners. Healy (2001) proposes revitalizing critical theory tradition by incorporating the knowledge of diverse actors in practice. Pilgrim (2009) refers to this as 'practice near' research. Research that is guided by a critical theory and more specifically critical social work practice theory can begin to explore multiple sources of knowledge in a local, contextualized way by paying attention to not only the power relations in micro-level interactions but also to how and if those interactions contribute to larger more meso and macro level structural outcomes. In addition, this perspective offers an avenue for exploring the potential ways that various actors create their own spaces of "counter-hegemony" (Gramsci, 1971), which can be understood as creating change or finding room to manoeuvre, as did some of the social work participants in my Master's research (Khoury and Rodriguez, 2015).

Critical social work practice theory emphasizes an analysis of power relations, structural inequalities, and retains a social change vision (Dominelli, 2002; Fook, 2002; Healy, 2001; Mullaly, 2007). Because critical social work theory generates knowledge within a transformative agenda, it integrates the opportunity to challenge and change constraining forces and oppressive conditions through individual and collective action. A critical posture requires going beyond understanding how individuals interpret or create their subjective reality to understanding how their realities are entrenched in potentially shared value meanings that can contest and change external forces and thus result in social change. As discussed by

Nurom (2008) and Kincheloe & McLaren (2005) a critical orientation questions political, historical, economic and societal structures in order to prompt transformations.

By critically engaging both practitioners and service users, research that uses critical practice theory can challenge the normative ideas, history, and power relations that impact practices and service users' experiences (Healy, 2005). Thus the researcher's task is to "clarify where changes are needed and how to accomplish them" (p.119). As presented in Part 1, both the recovery model and mental health practice are value-laden; critical practice theory allows for the synergy between values and social facts to remain intact as it does not treat them as separate phenomena. I am inspired by Healy's (2001) summary of critical practice orientations that connects macro social processes with micro social issues that professionals encounter in their practice. Healy (2001*)* maintains that a critical and reflexive stance can provide a clarification to the contradiction between policy and practice and allow professionals to work toward developing participatory practice relations in contrast to traditional authoritarian relationships. Morley & Macfarlane (2010) posit that "… in the context of mental health, [practice] must be informed by critical perspectives which emphasize an analysis of power relations, structural inequality, and progressive social change ideals" (p. 47) in order to challenge individualized and homogenized conceptions of mental health.

I am interested in determining what processes may be keeping participants in reinforcing the status quo; the idea is to acknowledge that a hierarchy of evidence and legitimacy does exist (Glasby and Beresford, 2006) so that it may be overturned. However, aligned with my critical research, I am also interested in knowing the perspectives of actors and how these actors in a specialized community mental health team create room for change and innovative approaches that surpass the current hegemonic structures. The introduction of an ethnomethodological approach will allow me to enrich my understanding of how actors make decisions and create action in their everyday settings.

Ethnomethodology

Ethnomethodology originates in a squarely interpretive tradition of phenomenology wherein the knowledge and common sense understandings of participants are foundational. Despite its name it is in fact a theoretical perspective that is in synergy with a critical practice perspective. The contemporary, social work critical theories presented above consider the perspective of diverse actors and the subjective narratives of lived experience to be indispensible. Ethnomethodology allows me to advance in this direction in establishing pertinent field methods that place interactions amongst actors at the centre. An ethnomethodological perspective guides analysis towards understanding micro-level and macro-level interactions as potential spaces of co-construction by breaking down social order and simultaneously attending to the circumstances in which participants are interacting. It goes beyond a simple description of social order and examines the practical ways social actors create and maintain their social order as a dynamic, artful accomplishment (de Montigny, 2007). In other words, it is a perspective that can complement a critical practice theory by guiding the study of the micro-level ways in which discourse, action, and service organization unfold naturally. Ethnomethodology maintains that social order is determined through interactions, rather than from than simply from the position of each interlocutor. If social order is built through interactional practice then the contextual understandings of participant experiences should not be separated from each other as separate and different in this perspective. Ethnomethodology, in its broadest sense, ask how participants, or interlocutors, interpret and draw upon their contexts to account for their actions and practices?

Ethnomethodology can provide us with insights to heighten our sensitivity to select notions and methodological issues. In this general presentation of this theory, I am conceptualizing ethnomethodology from a social work perspective. As such, I am inspired by several tenants of this perspective, specifically in the way it has been harnessed by social work researchers to date. de Montigny (2007) asserted that social workers need not approach ethnomethodology as "disciples eager to re-enact its...practices" but rather to engage with aspects of this perspective that can help practitioners and researchers break down the social order. Garfinkel (1967), who conceived of this perspective, says that it is not enough to examine a narrative or an interview to ascertain how and why events happened to someone and assume that that these events will be reproduced. For Garfinkel, the only way to know why things happen in a certain way is by detailing prospective accounts as events unfold. An ethnomethodological perspective is interested in the ordinary, practical, and accountable social order of everyday activities. That is, it is a perspective that supposes that social actors act in the world in an informed way that makes sense to them (Atkinson, 1988). Thus, for Garfinkel, social order is constituted of 1) retrospective accounts (with a shared vocabulary) and 2) prospective enactment of shared practices, thus, "studying concrete practices in the situations in which they are produced gives the researcher immediate access to the process of constructing local orders" (Rawls, 2000, p.128).

Ethnomethodological considerations provide a useful lens with which to discover the recovery-oriented activity of different actors in ACT teams by recognizing the role of institutional constraints on goals or values. An ethnomethodological influence as part of a broader interpretive inquiry opens up the possibility that unique expression of practice, or production of the social order, is concentrated at the interactional level (Rawls*,* 2000, p.130). Thus there is a focus on interactional practices in meaning creation (bottom up) rather than on a reliance on institutionalized meaning creation (top down). Discussing the usefulness of ethnomethodology for social workers in particular, de Montigny (2007) believes that it is a perspective that can help practitioners shift their attention from a world of objects to a world of social relations and social practices. A bottom up approach requires a contextual understanding of service users' experiences and a contextual understanding of practitioner experiences in order to locate the actions and interactions involved in mental health practice that are (or are not) entrenched in a recovery perspective, and is thus useful and pertinent for this study.

By studying the minute ways in which discourse, action, and service organization unfold, the ethnomethodological perspective allowed me to gain an understanding of "taken-for-granted" rules which shape the everyday lives of participants (Heritage, 1984 in Dowling, 2007). An ethnomethodological lens is congruent with my critical practice stance as it assists me in attending to flexibility and community mobilization rather than standardization or uniformization and in attending to participation rather than prescription in the actions and interactions of the ACT team. Its draws my attention to the actual activities of social actors, the reasons why they are engaging in these activities, and the circumstances or context in which the activity is taking place, thus allowing me to examine the practical use of recovery in participant' everyday lives.

In order to examine the concept of recovery, ethnomethodology allows for the development and discovery of criteria according to which participants may derive understanding through practical reasoning.[46] Some of these criteria may include a) what does it mean to be a recovery-oriented professional; b) what does it mean to be on a recovery journey; c) what dimensions are important in helping someone through the recovery process; d) what actions should professionals take in a recovery-oriented intervention approach; e) what signs or indicators help determine recovery; f) what is an appropriate recovery interaction between a professional and a service user. Ethnomethodology's focus on participant actions and interactions allows me to examine the micro processes and concrete practices that make up social order. The accomplishment of recovery practice and recovery values will be determined by examining concrete applied actions rather than investigating if abstract values (such as those found in normative accounts of recovery in policy) are applied in a top-down, technocratic manner.

3.2.2 Framing

The critical and ethnomethodological perspectives are soundly combined to inform an overarching framing perspective in order to explore participants' multiple understandings and meanings of recovery and the implications for recovery-oriented practice in an interview. A framing perspective has been used to study social movements (Benford, 1997; Benford & Snow, 2000; Gillan, 2007), discourse analysis (Skillington, 1997) and media studies (Entman, 1993;). These different research contexts, amongst others, use frame analysis to explore the ways in which groups and individuals select an aspect of their reality and make it more salient by "promot[ing] a particular problem definition, causal interpretation, moral evaluation, and/or

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[46] This is similar to the Wittengensteinian philosophy's investigations into the logical grammar of concepts. As discussed by Berard (2005) logical grammar is interested in describing the intelligible use of a concept or the critical features of that concept. Although that author refers to the potential overlap of logical grammars and ethnomethodology, there is almost no evidence of their simultaneous use in the relevant empirical literature. As such, I use the term criteria to denote the 'grammars' that make up the critical features of the concept of recovery

treatment recommendation" (Etman, 1993). Gillan (2007) contends that this points to three key aspects of framing being

> "that frames are often conceived of as an entity belonging to the collective level….[that] frames have a range of content consisting of a structured set of beliefs and values…[and that] frames are employed strategically by individual or collective agents to fulfill a variety of social movement tasks" (p. 2).

Frames make explicit how discourse exerts power by "illuminat[ing] many empirical and normative controversies" (Entman, 1993*,* 55). Perri (2005) states that frames can provide a link between sense making and action bias. In this capacity, it is a relevant concept as it will allow me to explore the links between recovery meaning and recovery activity.

In his book Frame Analysis , Goffman (1974) asks question "what is it that is going on here" and "what is salient" to the actors in this situation. According to Benford (1997) "meaning is pivotal" to the framing perspective and Goffman's initial posture was that different people will have different understandings or meanings available to them in order to make sense of what is going on and guide future action. He referred to these as "frames of reference" and his perspective also allows room to analyze the context and circumstances that might affect these frames of references.

Specifically salient to mental health and professional practice, Kleinman, Eisenberg, and Good (1978) and Healy (2005) discuss the role of framing. Kleinman et al. (1978) elaborated an explanatory model of illness to understand, in contrast to a biomedical model, how individuals experience illness or disease and how this experience is nuanced by the way the illness is conceptualized. Explanatory models, or frameworks, are sets of assumptions about the causes of a phenomenon (Lynch & Medin, 2006) and are meant to assist service users and practitioners in sharing information. As discussed by Bhui & Bhugra (2002), Kleinman et al.'s (1978) original approach included a series of eight open-ended questions in order to elicit the explanatory framework of the individual. This leads to an explication of a frame of reference that is nuanced by social norms, rituals, symbols, knowledge and cultural diversity which allows for a better understanding of a person's experience, including its meaning to them and their expected recovery process. An explanatory framework of recovery would thus consider notions of recovery and its application by all those involved in the process.

Healy (2005), in a complementary fashion, contributes to a framing perspective by discussing in detail how social work professionals construct their framework for practice through every interaction they have. She posits that over time formal theoretical knowledge combined with informal tacit knowledge results in a practice framework that allows professionals to "[construct] unique responses in each practice encounter" (p.216). The nuance that Healy provides to a framing perspective allows for professionals to claim a certain amount of flexibility in order to transform ideas or rhetoric that they are exposed to during their concrete application. It opens up the opportunity to analyse and ask: how are service user difficulties and experiences influencing the type of recovery-oriented practice interventions envisioned by the service provider? How do the circumstances such as poor social networks or poverty, influence the negotiation and co-construction of interactions, interventions, and outcomes?

3.2.3 Citizenship and recovery as a conceptual framework: a critical reading of mental health recovery

The latest mental health policy in Québec refers to maintaining desired social roles as a path to both citizenship and recovery, demonstrating that attempts to renew the concept are using the term citizenship (Davidson et al., 2010; Government of Québec, 2015; Pelletier, Davidson & Roelandt, 2009). Thus, citizenship is a complex and complicated concept that is pertinent to unpack.

Shifts in our healthcare delivery system in the last half century from an asylum model of care to ambulatory care and most recently to community care creates the possibility of citizenship and community life for service users who once were stripped of basic human rights and almost all forms of citizenship. Davidson et al. (2001) cite social inclusion as a "basis for recovery from mental illness" (p.375) as it will "lead to the process of restoring citizenship" (p.386). In other words, citizenship is a foundation for, rather than following after, mental health recovery (Davidson et al., 2010). Pelletier et al. (2009) refer to a global model of mental health that includes citizenship as a better way to understand core features of recovery as a social process that "seeks the social inclusion of people who have been marginalized and segregated" (p. 47). In France, Roelandt & Desmons (2002) and their colleagues have been writing and exercising the idea of citizen psychiatry, which focus on human rights, reducing inequalities through an attention to social determinants of health, and improving upon poor natural support systems.

As a research *object*, recovery plays an important socio-political role in the development of policy and practice rhetoric. However, it is also a conceptual framework through which mental health practice and service user experience of this practice will be analyzed. The critical practice, ethnomethodological, and framing perspectives guiding the analysis of this research study provide a unique position from which to read recovery in order to explore social, political, and economic processes through which service users and service providers engage in, and understand, their daily interactions and creation of social order. As a critical practice researcher I reposition recovery through a lens of citizenship to consider the structural influences of living conditions, inequality, and social exclusion. This larger understanding offers a theoretical starting point to understand the relationship amongst individuals, groups, and society.

The literature suggests that theories of citizenship have evolved and multiplied since T.H. Marshall's seminal work on the subject in 1950 entitled Citizenship and Social Class and Other Essays. At that time, Marshall defined a postwar theory of citizenship in terms of the possession of rights in which a liberal welfare state guarantees civil, political, and social rights to all. Marshall underscores the importance of social (read: welfare) rights for all. As stated by Kymlicka and Norman (1994) the rising interest in renewing a definition of citizenship is due to a consideration of the "social and cultural pluralism of modern societies" (p.355) as well as the consideration that contemporary public policy relies on responsible citizens. A recent survey of citizenship theory by Kymlicka and Norman (1994) discusses how conservative thinking in the 1980's referred to this postwar political theory of citizenship as passive citizenship because it is focused solely on rights at the expense of obligation to participate in public life. In today's political landscape "citizenship involves both rights and responsibilities" (Kymlicka and Norman, 1992, 358). This echoes many recent writings on recovery that refer to the process as "restoring rights, responsibilities and social roles" (Webber & Joubert, 2015, p.i).

However, a critical reading of citizenship understands that it is not viable if structural barriers to participation are ignored. This is particularly pertinent to consider in this study because all of the service users of the ACT program face these barriers on a daily basis. As discussed by Lister (2007), Bartlett & O'Connor (2010), and Young (1988) amongst others, citizenship itself is a contested concept therefore it needs to be contextualized in order to mitigate the inherent exclusionary practices that can be produced by a normative account of citizenship. Lamoureux (2001) and Pelchat (2010), along with others such as Young (1989), put forth a theory of citizenship that is inclusive, plural, and critical. I am influenced by the feminist author, Iris Marion Young (1989), whose discussions on citizenship led the academic literature in understanding the importance of a differentiated concept of citizenship stating:

> "rights and rules that are universally formulated and thus blind to differences of race, culture, gender, age or disability perpetuate rather than undermine oppression" (p.267).

This concept of "differentiated citizenship" (Young, 1989) critiques the way in which universal theories of citizenship are blind to individual differences. Young (1989) examines the idea that universal, homogenous conceptions of citizenship cannot lead to full citizenship for all because socio-economic activities are not citizen-run and perpetuate disadvantage for some and privilege for others. She argues that mechanisms for group representation, "the articulation of special rights that attend to group differences" (p.251), are imperative to realizing full inclusion and participation for all. Clément (2008) refers to three issues related to accessing full citizenship from 'the margins'. This includes the importance of acknowledging that excluded members of society experience barriers to equal rights, inclusion and participation, and recognition. Lamoureux (2001) conducted a participative, qualitative research study in order to understand and name the representations of citizenship developed by community groups in Québec. This study included a vast analysis of documentation from community organizations and the participation of 102 people involved with the organizations.

Through field observation and semi-structured interviews one of the author's conclusions is that the development of political citizenship[47] must be emphasized. The participants in this study referred to citizenship as the "*possibilité pour les gens de prendre une part réelle, significative, réfléchie et efficace dans les affaires qui concernent le bien commun*" (p.35). This study also illustrated how citizenship is multidimensional and plural with different community organizations advancing differing perspectives of citizenship resulting in Lamoureux's affirmation that

> *"prendre une place en tant que personne à part entière, retrouver sa dignité, intégrer ou réintégrer significativement l'espace du vivre ensemble….la citoyenneté est une réalité complexe, multidimensionnelle et controversée" (p.35).*

O'Connor (2007) in Bartlett and O'Connor, (2010) provides a framework in which citizenship transverses personal experience, interpersonal relationships, and a broader societal context. The author posits that this framework allows for an analysis of "particular values, beliefs and assumptions [that] are enacted at broader organizational, systemic and societal levels." (p. 27) that also acknowledges the bidirectional nature of co-constructed and negotiated mental health practice. Bartlett and O'Connor (2010) also provide 6 dimensions of social citizenship that include growth, social position, purpose, participation, solidarity, and freedom from discrimination. All of these dimensions are relevant to an emancipatory and participative ideal of recovery.

Typically the literature points to rights, responsibility, and participation as key elements of citizenship (Bartlett & O'Connor, 2010; Pelchat, 2010; Lamoureux, 2001;

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[47] Kymlicka and Norman (1994) refer to a political citizenship in which citizens are able to, and perhaps even obliged to, evaluate the work of elected leaders, question authority, participate in public debate, and respect others.

Mezzina, Borg, Marin, Sells, Topo & Davidson, 2006), but Jubas (2007) outlines 6 required factors of citizenship: rights, responsibilities, residence, resources, recognition, and resistance. She highlights resistance as an element of citizenship that speaks directly to challenging global hegemonies, normative concepts, structural inequalities, individualizing forces, and social norms that perpetuate marginalization and exclusion. Clément (2008) also includes the importance of recognition, stating that in order for marginalized groups to reclaim their full citizenship, they must not only be included and participate, but must also be recognized as a subject[48]. With a focus on improving our personal space (via individual evidence-based therapy) at the expense of our inter-connected, public spaces, Pelchat (2010) and Clément (2008) question the democratic and transformative scope of 'participation' and user-involvement' as used in policy and practice. I identify with a theory of citizenship that includes critical judgment, sharing of public space, and popular education; a theory of citizenship that is plural and heterogeneous in order to be inclusive of a variety of realities. Citizenship that recognizes difference as valuable, essential, and unavoidable is the bias with which I am pursuing this analysis.

Rowe and Pelletier (2012) discuss Crabtree and Chong's (2000) analysis of citizenship theory as one that is central to issues of mental health. They explain that because citizenship is necessary for an individual to dialogue with the State, mental well-being and mental health are now a prerequisite for the health of democratic societies. They explicitly discuss how stigmatization obscures the capacity to participate and argue for the necessity of public mental

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[48] That is they must be recognized by others as members of society and they themselves must be empowered and hopeful.

health services that can support members of society in becoming and maintaining equal citizen status. This review of citizenship demonstrates that the process of reclaiming citizenship is one that extends beyond the individual and even beyond the institutional structures. However, how can that integrate with the concept of recovery as a research *object* when authors with lived experience such as Deegan (1998) maintain that it remains a singular and unique journey. One helpful perspective is articulated by the psychoanalyst, Jean Furtos. He believes that in order to promote the well-being of the person even in a clinical space and during individual interventions it is necessary to create or support spaces of resistance to a dominant legitimizing force that is not necessarily in the person's interest (2007). What professional practices allow this and how is it possible to create larger, communal social projects as well as paths toward personal emancipation?

Following the above explications of my personal standpoint, I position recovery as more than 'simply' overcoming a mental illness. It includes addressing larger issues of social and economic inequalities and the importance of social inclusion. This broader use may provide a foundation to the relationship between an individual recovery journey and collective society. This postulation is informed primarily by two positions found in the literature. The first being that citizenship is a foundation for, rather than following after, mental health recovery (L Davidson et al., 2010). The second is that an individual is linked to society via a unique social project through which she tries to create positive change (Ware et al. 2007). Departing from the initial understanding of this position by these authors, I consider that the individual creating positive change can be any person, service user, practitioner, and ordinary citizen. By revisiting recovery in this way, and by rejecting the neoliberal intrusion on the word recovery that has been taken over by homogenising outcome measurements, ignoring social determinants of health, and focusing on the individual whilst overlooking political and social influences and consequences, I intend to reclaim the dynamism that initially placed the word at the centre of mental health practice.

The theoretical lenses elaborated in this project are used to explicate how the observed actions and interactions between service users and service providers, and their understanding of their social order, might be understood in a critical, citizenship-based recovery perspective. This requires recognizing participants as co-constructors of micro-level interventions and meso-level environment and context. This combined, critical perspective brings my attention to activities, circumstances, and interactions that are related to flexibility, community mobilization, community engagement, reflexivity, subjectivity, and participation.

3.2.4 Combining theoretical traditions: a final word

The crossing of these theoretical traditions in my analytical framework (for which the operationalization will be outlined in the next chapter) serves to strengthen and complement interdisciplinary traditions. The use of multiple frameworks is coherent with qualitative research and can in fact enhance research in order "to see in new and different ways what seems to be ordinary and familiar" (Anfara & Mertz, 2006). Qualitative mental health researchers such as Padgett & Henwood (2009) discuss in detail the use of multiple theoretical lenses for an empowerment-oriented qualitative study of homeless mentally ill adults. Similarly, Conroy (2010) argued for the use of multiple concepts, including ethnomethodology and critical theory, to study everyday life, which is loaded with multiple meanings.

Thus I can examine ACT teams as entities that are themselves embedded in everyday practice. This bottom up approach is consistent with my position that recovery-oriented practice is most holistically explored through an understanding of policy, service organization, and interactions amongst social actors. An understanding of the current social order and the methods by which that social order is practically achieved is the first step to practice renewal. This is not only consistent with my critical position but also demonstrates how an ethnomethodological approach potentially paves the way for change to happen by focusing on how relationships and practice might change when actors are aware of and reflexive of the effects of their actions and interactions and also of what contributes to their actions and interactions (de Montigny, 2007*)*. If I am to account for things going on in the world of community mental health, then I need to find out how members theorize their practice, and particularly recovery-oriented practice. It is, then, members' 'practices' that hold the 'data', which demonstrate that this theorizing is successfully accomplished. However, ethnomethodology does not attend to values or beliefs in so far as they are part of what recovery is about. In order to identify normative aspects of what is a recovery journey and recovery-oriented practice we must turn to another perspective. Inspired by a framing perspective elaborated initially by Goffman (1974) and more pertinently by Kleinman et al.'s (1978) and Healy (2005), I will be able to understand how participants conceive of recovery. Thus, with a framing perspective I can compare participants' recovery rhetoric with recovery action by attending to meaning construction, values, and beliefs.

In sum, I position myself as an activist that "intervene[s] on hegemonic practices and serve[s] as an advocate in exposing the...effects of marginalized locations while offering alternatives" (Fine, 1994 in Madison, 2012). de Montigny (2007) states that social change is only possible once social processes are understood. Thus, my multiple theoretical lenses together allowed me to understand how recovery-oriented practice is constituted, the values and beliefs that are central to recovery processes for participants, and finally provided insight into further developing recovery-oriented practices and alternatives to current biomedical practices. The chosen theoretical approach presented above is firmly situated in the qualitative tradition of research. Creswell (2014) discusses three types of research designs: qualitative, quantitative, and mixed methods and the assumptions that drive the selection of one over the other. This research project followed a qualitative tradition in order to explore and understand the meaning participants prescribed to their daily interactions and lived reality. An emphasis on interactions, processes, and "privileg[ing] the point of view of social actors in apprehending social realities" (Mayer, Ouellet, St-Jacques, Turcotte et coll., 2000, p.159-160) are hallmarks of qualitative research. This research design requires an analytical process that decodes subjective participant meanings, processes, values and beliefs. The value of qualitative research comes in contributing to concepts and theories that are used more widely and are therefore more generally applicable. It is representative in as much as the things we learn from it can have meaning for other situations (O'Reilly, 2005, p.199).

The aim of the inquiry was not simply to understand and reconstruct the social relations within an ACT team. It was also to offer a critique of current social structures within an ACT team and understand the role of ACT in the lived reality of service users as citizens. Until recently, research regarding mental health problems and practice has been largely focused on biomedical explanations and treatments with a continued pessimistic, chronic view of psychiatric and social difficulties. More recently, both research and practice have moved toward the recognition of experience-based evidence (Beresford and Croft, 2001; Beresford et al., 2010; Rodriguez et al., 2006) and thus the need to explore the meaning and lived experience of both mental health problems and mental health care. Moreover, a more recent recognition of the role of poverty, inequalities, violence, unemployment and other structural factors, collectively referred to as social determinants of health, has placed research into mental health issues in the spectrum of critical inquiry requiring a methodology that considers intimate involvement with a setting as necessary for understanding local meaning, actions and interactions.

In my research the inductive approach allowed me to explore and understand the patterns, attitudes, and behaviours that influence the interactions amongst participants within the ACT program. The study is looking at a phenomenon that is in constant movement - the subject of inquiry is not simply the operationalization of a recovery orientation but the process by which a recovery orientation may be acted out and lived by the participants. I am interested in the meanings and understanding that service users and ACT professionals attribute to their daily interactions and to the events and contexts that affect the personal narratives of people living with mental health problems. What kind of recovery do members of this urban Montreal ACT group create? How does it evolve from their experience of the world and their joint construction? If they are communicating this recovery perspective, how are they doing so?

Chapter 4: Methodology and research methods – immersion in the intensive community mental health program

The preceding problem statement and theoretical framework outlines the necessity to better understand how recovery-oriented practice is produced as an intersubjective co-construction, or interactional practice. The present chapter outlines the research objectives and research methods that I used to understand individual reconstructions and interpretations given to life experiences of participants both inside and outside of the ACT clinic. This will include a detailed description and rationalization of the data collection and analytical strategies used.

The method of inquiry, inspired by critical ethnography, fits within a qualitative research design and subscribes to an interpretive paradigm. This methodology, which requires proximity to participants and their actions and interactions, allowed me to authentically identify taken for granted practices and common sense beliefs. It also afforded me the time and space to examine my own assumptions and procedures and check in regularly with the participants. The field research for this study took place from January to July 2014 with an ACT team in Montreal's south-central downtown neighbourhood. It consisted of participant observation of various interactions and meetings in several different places pertinent to the participants, notably in the homes of service users. It also consisted of individual interviews with 12 service providers and 6 service users.

4.1 Research methods

Based on the concerns identified in the problem statement and on the research perspective proposed in the theoretical framework, this study is articulated around the following question:

How are the meanings and common use of recovery and recovery-oriented practice constructed in a specialized community mental health team?

My hypothesis was that there would be significant tensions arising from the central objective of ACT, the recovery discourse, and predominant reductionist biomedical practices. When I began participant observation in January 2014 and semi-directed interviews in March 2014 I expected to unearth tensions between service users and service providers because this is what I had informally observed in my previous clinical and research work experience in psychiatry. I expected that service users' mental health problems would be exacerbated by a culture of care entrenched in a traditional, reductionist psychiatric model of oppressive practice, social control, and a stripping of citizenship rights. I also expected that the literature on ACT as the "institution without walls" (Dorvil, 2005) and the "biomedical hegemony" in specialized psychiatric care (Cohen, 2005; Gomory et al., 2011) would play a significant part in the portrait of a service users' subjective and intersubjective relationships with service providers.

4.1.1 Research Objectives

Informed by ethnographic methods, the objective of the present analysis is to shed light on the interactional experiences of providing and of using services from an ACT program. This research was focused on understanding the daily social actions and interactions of the various actors involved with an ACT team in order to understand pathways for the development of negotiated interactions amongst relevant actors that are sensitive to the polysemic nature of recovery, citizenship, and diverse experiences. In this study I explored the processes by which mental health professionals negotiate the meaning and usage of their practice approaches with service users and how they co-construct their interventions to:

1. Explore how recovery-oriented practice is accomplished
2. Gain a deeper understanding of what recovery means to both service users and service providers in community mental health practice
3. Uncover any potential organizing principles in ACT programs that help service users take on a citizenship role that empowers them to co-create supportive communities within the service and in the community

Specifically[49], this study hopes to: understand and explore actions and interactions and points of contact between service users and the ACT team (service providers, partner institutions); understand the local, lived reality of an ACT team in an urban Montréal setting; explore the meaning of recovery and recovery-oriented practice through discourse and actions.

The remainder of this chapter is dedicated to explaining the methodology that influenced this study and the analytical strategy used to accomplish this research.

4.1.2 A research methodology inspired by critical ethnography

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[49] Initial objectives included: Develop a better understanding of the relationships and actions and interactions within a local ACT team; Explore whether these interventions and relationships are congruent with the values, dimensions and approaches that characterize recovery; Ascertain through interactions with diverse actors how they negotiate the meaning and role of the ACT program in the community and in the lives of service users; Analyse how the processes and results of these daily interactions shape and transform community mental health practice; Analyse how the role of ACT team shapes or transforms the lives of service users in the community.

In his 2009 article on mental health recovery, David Pilgrim posits that changes in practice and challenging the hegemonic practice culture can only be done through

> “context-dependent, practice-near accounts…generated by ethnographic research, which attends to particular actions judged in particular circumstances, with views recorded from a range of perspectives” (p.477).

He concludes by asserting an “ethnographic challenge” in order to uncover the meaning of recovery for different actors in a particular context which he refers to as ‘practice-near research’. The rarity of this type of research in mental health social work means that the intersubjective scenarios carried out within a clinical setting do not always account for plural perceived realities.

After considering a number of approaches within social work, my insistence on methods and methodologies that kept an emphasis on context, power, and systems of meaning, increasingly drew me to the anthropological influences on social work. The sociological and anthropological influences on me as a social worker and as a social work researcher represent a movement towards a fidelity to social work in an interdisciplinary sense that enriches and enhances the production of knowledge and the understanding of knowledge. Moreover, adopting an ethnographic approach – at least in the sociological and anthropological vein – left the precise question or exact topic to be investigated somewhat open, and permitted space to be held for participants to lead me to important subject matter. Ethnography was a way for me to study an ACT program’s relational practices, participants’ common values and beliefs, and the experiences of the participants in order to better understand the inner workings of the participating ACT team (Maso, 2001). In short, an ethnographic influence allowed me to develop an understanding of the inner workings of the team – and attempt to answer the fundamental question ‘are they recovery-oriented?’. The methods that make up an ethnography such as various participant observer approaches were used to get inside the 'world' of an ACT team to understand how diverse interventions and intervention planning become structured through the ordinary, daily interactions between the service user and the service provider. This goes beyond looking at the social order, which is just one aspect of a culture, since interventions, and ultimately the underlying value system that animates a recovery orientation, is deeply rooted in the organizational culture and context.[50]

As discussed by Carter and Little (2007), explicating methodology is a way of justifying the research design's relationship to theory. They also stipulate that methodologies and can be altered in so long as the researcher's epistemological position remains coherent. It is in that spirit that this inquiry allows for an inspiration from the methodologies inherent in ethnography. I was initially excited to explore ethnography as a methodological possibility. It seemed to offer a rich methodological literature and epistemology, well-suited to my research aims of maintaining a contextualized, reflexive, holistic account of social actions and interactions in an ACT team. Although I cannot claim that I have conducted a "formal" or "traditional" ethnography, I was significantly influenced by ethnographic theory and method in conducting the present study as a way to provide an informed reflection based on real world contact with mental health service users and providers in a highly marginalized and simultaneously gentrified urban area for a sustained period of time.

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[50] Important distinctions between ethnomethodology and ethnography should be clarified. Ethnomethodology is a *perspective* concerned with social order, one aspect of a larger cultural model that ethnography, a *methodology*, aims to uncover through its methods of immersive observation. In addition, ethnomethodology distinguishes itself from ethnography by 1) the distance that ethnography maintains from the social order being studied; 2) ethnography's inability to recover the lived social order; 3) lack of reflexivity that does not allow ethnography to examine its own assumptions and procedures (Polner & Emerson, 2001). As part of the theoretical framework and orientation, ethnomethodological insights "can be used selectively to heighten sensitivity to fundamental methodological issues and to augment appreciation of the practices of both the subjects of ethnography and ethnographers themselves" (Polner & Emerson, 2001, p.3)

My previous research exposure as a graduate student and as a research assistant was fundamental to shaping the methodological approach of this research project. However, the elaboration of this ethnography was only possible due to the openness and accessibility granted to me by the ACT team members. As a graduate student I worked on research projects wherein service providers chastised a more simple qualitative approach that consisted solely of individual interviews. They, like the service providers who participated in this research project, wanted to be observed, to be in interaction with the researcher, to be in dialogue with diverse actors, and to develop a better understanding of their shared beliefs, behaviours, and language. In order to respond to the above objectives, ethnographic methods were elaborated, which privilege the perspectives of diverse social actors in the understanding of diverse social realities (Mayer et al., 2000). As noted in the previous chapters, research on community mental health practice has often stopped short of getting close enough to practice to produce understandings of what goes on between service providers and service users. Ethnographic research, or practice near research (Ferguson, 2016; Pilgrim, 2009) consists of fieldwork (Whitehead, 2005), observing encounters as they naturally occur (Hammersley and Atkinson, 2007), and "gathering data through participant-observation in a natural setting" (Floersch et al, 2014, p.5). An ethnographic investigation will deepen our understanding of the social problems encountered by participants by unearthing the meaning and significance of their social interactions through observation of their discourse and practice.

The posture of reflexivity that I adopted has positioned this study as a critical ethnography (see Annex 1 for details). It is a research project in which I was constantly aware of my positionality, continuously reflexive, and considering the effects of the research objectives and results on the participants (Madison, 2012). It is an approach that is inextricably aligned with an explicit awareness of “taken for granted” social practices and common sense entrapments and seeks to describe my observations, like in conventional ethnography, but also to ask how things could improve or change for marginalized or vulnerable peoples. Proponents of reflexivity understand positionality as essential to critical ethnography, which presented itself as an alternative to the supposed “value neutral” inquiries of past ethnographers and many other empirical methods (Madison, 2012; Thomas, 1993). Also, in order to remain aligned with my chosen combination of theoretical traditions, a similarly strategic methodological choice that is interdisciplinary was needed. Gunzenhauser (2004) supports the idea that a critical ethnographic methodology can be strategic in that the various strengths of these traditions are combined to some extent to correct or augment the deficiencies of a single perspective. He argues that theory and methods, so often separated both in research training and in practice, are in fact inextricably combined. Essentially, the ethnographic methods coupled with a critical, reflexive posture allowed me to explore how participants identify their priorities and experiences, expose their social relations, and how they might notice opportunities for change. This lays the foundation for his explanation, with the support of various authors, of critical ethnography being a methodology that refuses to separate theory from methods.

I would like to highlight the relevance of critical ethnography in social work research. Riemann (2005) is a social work researcher who argues that social work professionals (and others involved in direct social interventions) who are familiar with different interpretative research methods can transfer that knowledge to their practice approaches. Similar to the perspectives outlined in Chapter 3, Riemann (2005) argues for social workers to be self-reflexive ethnographers of their own practice in order to develop a “systematic approach to social reality as something which should not be taken for granted and the strangeness of which should be appreciated…[and understood]” (p.89). In a similar vein, Bransford (2006) explains how a critical ethnography can be used as a methodology to help social workers to become “more consciously aware of how they take up their professional authority in managed mental health care contexts” (p. 173).

Despite a few examples from the literature on the inspiration and relevance of using critical ethnographic methods in direct practice, there was almost no evidence of social work research taking place using these methods (although examples from sociology and anthropology abound). A search on databases such as Social Services Abstracts and Social Work Abstracts unearthed only 1 social work research article that used this methodology. In this article, found in *Health and Social Work*, Law and Saunders (2016) employ a critical ethnography in order to understand the quality of participants’ experiences on the board of directors of a community health care centre. Despite the very recent use of critical ethnographic method, it’s questioning of the relationship of social order and social structures and its methods of “reconstructing social reality by privileging multiple voices” (Law and Saunders, 2016) are techniques indispensible to describing and explaining relationships between people and systems with in the larger political, economic, social context (Carspecken & Apple, 1992). In any case, it always calls for the researcher to immerse herself in the exercise of understanding social relationships, social actions, and interactions as well as context.

4.1.3 Research techniques: Field work anchored in the world of Assertive Community Treatment

Before embarking on my fieldwork I envisioned conducting interviews coupled with direct observation in order to explore the daily "actions and interactions amongst service users, service providers, and others" (Khoury, 2013). I developed methods to "honour complex subjective and phenomenological meaning" (Madison, 2012, xi), which are also "concerned with social justice, critical analysis and the ethical demands of fieldwork methods" (ix).

I entered the field through an initial contact with the team leader, a social worker by profession. Our shared backgrounds as mental health clinicians and social workers concerned with mental health recovery resulted in open and frank conversations and a mutual, relational affinity. As such, I was invited to meet the team and present my work. The team was unexpectedly excited to learn more about themselves and their daily actions and interactions with service users. In January 2014 I began an initial exploratory week immersed with the urban Montreal ACT team. During this time I discovered that within this urban ACT team there existed explicit tensions between a desire to be patient-centred and recovery-oriented, a confusion with the meaning of recovery, and a practice reality entrenched in a restrictive biomedical model of care. In short, after meeting with service users and service providers during the exploratory week of research I learned that this urban ACT team was indeed a space in which new practices and orientations were in constant negotiation with old structures and traditional paradigms.

The field research took place from January to June 2014. It consisted of participant observation[51] in many clinical and community settings with service users and service providers as well as observation of team meetings, internal meetings, and partner meetings. I also conducted individual interviews with key actors. Thus, with a qualitative, ethnographic methodology my field research was conducted. I observed ACT weekly team meetings (approximately 10), partner meetings with the admitting units (2), daily 11 am logistics meetings (approximately 60)[52], meetings and outings with service users (approximately 8), visits to service user homes (approximately 30), and meetings between service users and psychiatrists (3). I also spent significant time observing the daily actions and discourse of service providers in the office and in transit. I completed 12 semi-directed interviews with service providers and 6 semi-directed interviews with service users[53].

The present study assumes a reflexive, immersed, critical posture throughout the research. It is purposefully an iterative research design where I swing back and forth between research, data collection, and analysis focused on experiences, discourses and interactions (Glaser & Strauss, 1967). In the following section I will outline the methodological aspects of this study, the data collection, and the analysis. I will also detail the strategy used to implement this research inquiry.

Sampling, selection, and recruitment

With a research perspective inspired by ethnographic methods as described above, the adoption of a research strategy based on participant observation imposes an open research

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[51] Participant observation took place between January 14, 2014 and June 26, 2014

[52] I observed many daily logistics meetings because it helped to keep up with each service user narrative

[53] An 7th service user interview was scheduled and informally initiated when the service user declined to continue. This will be detailed further below.

structure wherein the construction of the object of study can't be fully identified through a conventional procedure of representative sampling of a target group. As such, the selection of participants and situations to study was made through a concern for theoretical pertinence to better understand the inner workings of the ACT team, rather than through a concern for empirical representation. In other words, keeping true to an inductive research approach, this qualitative research project samples purposively; the participating ACT team was selected to serve an investigative purpose rather than to be statistically representative of a population (Ritchie, Lewis, & Elam, 2003*)*.

With this in mind, I decided to focus my research on studying a case in which multiple vulnerabilities and complexities exist, and wherein access to the voices and lives of many different actors was possible. With the goal of deepening my understanding of daily actions and interactions in an ACT team as well as the social, economic, and political context, I focused my efforts on integrating into a team that was open and willing to participate, to share their internal relationships with me and their relationships with service providers and actors in the local community. My analysis considered the relationships cultivated within and without the ACT team and also the relationship participants have with social or socio-economic difficulties and vulnerabilities.

Negotiating access

I knew many things about my topic – that is to say, mental health practice, institutional structures, and recovery-oriented practice. But there were many other things I did not know much about such as, the lived experience of people living downtown and using ACT services or even the modes and modalities (inner workings) of an ACT team. Moreover, I knew that I had to plan access very well, drawing on my professional experience and my networks built in a decade of mental health social work practice.

I negotiated access drawing on contacts I had made through clinical experience and past research work. In the summer of 2013 I began initial contacts to determine which ACT team could participate. I initially considered the ACT team at the mental health institute where I used to work as a social worker because 1) it is considered to be in an urban location; 2) I have studied with the researcher who reviews all of the qualitative CER requests and; 3) I figured that as an employee (at the time) I could easily establish trust. In the end it was decided that such proximity to the team could negatively influence or bias the data collection and analysis of results. However, another ACT team in an urban Montréal territory was contacted; as I mentioned above they were receptive to research and felt they greatly benefitted from participating in previous research on ACT.[54] At the same time, in the fall of 2013, I obtained my ethics certificate from the *Université de Montréal*.

My previous work as a research assistant (Poirel et al., 2015) helped secure my initial entry into the team. The researcher with whom I had worked had once collaborated with the team lead, *Christine*[55], and through this positive collaboration I was able to 'cold call' her. She said one of the reasons she accepted to meet with me, other than our common professional background and experience, was because I was referred by this researcher whom she trusts.

My experience and background as a psychiatric social worker were key elements to obtaining trust from the team and approval from them to immerse myself into their daily work

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[54] Many team members had previously participated in the pan Canadian 'At Home' research project which examined Housing First as a means of ending homelessness for people living with severe mental health problems in Canada

[55] Names of all participants as well as other service providers and service users that I encountered in the course of this research have been anonymized to protect confidentiality

life. My professional presence was not intimidating or out of place and I easily became a piece of the puzzle. Many times participating service providers told me that they felt like I was part of the team. This helped me be 'around' many situations to observe. Sometimes it was difficult because some team members would ask for my professional or clinical opinion. In these situations I would try to answer in a way that did not disturb the conversation or the meeting but also deflected away from my own clinical impressions so that I was not interfering too much in any clinical decision making processes.

Following an October 1, 2013 conversation with *Christine* as well as documentation I had sent her[56], she accepted to participate. I then proceeded with the ethics approval at the parent institution (a teaching and research hospital) affiliated with this ACT team. In November 2013, I met with the whole team for the first time. My goal was to ensure engagement and buy-in for the research. I presented the project as pertinent by creating trust with them and reminding myself how, as a service provider, I would have felt about being observed/shadowed by a researcher. Most importantly, I wanted them to feel a professional affinity toward me and to know that I could ease into their team without too much disruption. I told them that I was committed to ensuring that the project was meaningful for them and to find the intersection at which my research objectives and their practice concerns meet. I told them that I am preoccupied by making the contributions of their practice visible and that I

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[56] My initial email to *Christine* reads as follows:
"Je suis une travailleuse sociale professionnelle et depuis 2004 je travaille en psychiatrie (2ieme et 3ieme ligne). Mon parcours académique est un changement de carrière et j'étais du monde professionnel et clinique depuis plus de 10 ans avant d'entamer mes études doctorales. Je comprends et je connais la réalité quotidienne des intervenants et avec mon expérience de travail je vais pouvoir m'accommoder à vos conditions de travail. De plus j'ai déjà travaillé avec 3 projets de recherche (dont un qui était mon projet de Maîtrise) où j'ai fait incursion dans les milieux psychiatriques pour rencontrer des intervenants et personnes utilisatrices. Bref, je tiens à vous assurer que si vous et votre équipe êtes intéressé à participer à ce projet, vous n'avez pas à modifier votre organisation de travail ni à créer des disponibilités spécifiques. Avec mon expérience je peux être introduite dans l'équipe comme observatrice sans vous importuner » (September 9, 2013)

have a research perspective that is respectful of workers and service users. I also, for transparency, told them that there are critical elements to this research project and I am committed to elaborating and discussing with them. I wanted to convince them of the impact this research can have on service user and on service providers (how do they do things creatively; what invisible work are they doing?). I told them that knowledge transfer is bi-directional and that I am there to learn with them and from them. I told them that with my experience as a service provider and as a researcher there might be things that they don't see that I might notice in my observations but that I am committed to a respectful process of explicating that. The message I focused on in that first meeting is my preoccupation to *« mettre leurs pratiques en lumière au service des personnes usagères »*.

Inclusion and exclusion criteria

The main inclusion criteria for this study was that participants were service users or service providers in the ACT team; were willing to discuss their experiences and opinions about ACT, their professional or personal narrative, the concept of recovery; and had a desire to provide input that could possibly lead to a better understanding of practices and relationships in the ACT team. All service users and providers in an ACT team are at least 18 years old. Although there is an formal age limit of 65 years old as part of the inclusion criteria of the ACT team itself, this was not rigidly maintained by the team. As such, a few participants were aged between 65 and 70 years old.

The team leader*, Christine,* recruited services users for observation and for interviews as agreed when I was negotiating access to the field work. However, I did have the opportunity to explain to *Christine* the sampling methodology I was aiming for. Following Rubin & Rubin's (2005) recommendations for interview sampling, I aimed to recruit people that were willing to talk, have some knowledge of the culture being studied as well as the problems being studied, and offer varying perspectives[57]. There were purposeful attempts on my part to ensure a representative sample of service users – some who have recently been accepted into the ACT program, others who were part of it from its inception in 2009 as well as age and gender diversity. Although young adults have not experienced the asylum in the same way as some of the older participants and their experience in the system is less expansive, the contributions and perspectives they brought to the study were invaluable. As per my methodological notes (January 28th) I think service users agreed to participate in the project because they have a strong trust and therapeutic alliance with the service providers who were also sincerely interested in the project.

Participants

According to *Christine*, the team of 10 service providers and 2 psychiatrists should have a total caseload of not more than 80 service users. However, at the time of data collection the ACT team had 100 registered service users. Most participants included service providers and service users who agreed to allow me to observe their meetings and interactions. However, all of the service providers (12) and 8 service users also agreed to semi-structured interviews in addition to being shadowed and observed. They were all interviewed except for two service users. One of the service users whom I did not end up interviewing was extreme mobile and hard to reach. In essence, we kept missing each other. The second service user

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[57] Varying perspectives refers to the different points of view and issues occurring within the field of mental health. For one thing the mental health community is divided along philosophical lines within the field as a whole and within local teams and programs. These divisions support different views on what will bring recovery, well-being, inclusion,and active citizenship to those living with or having lived with mental health problems as a whole.

whom I was able to follow in observations declined to be interviewed during his hospitalization which lasted for the majority of the time that I was with this team.

When I began the study I kept separate files for each participant that I was both observing and interviewing but along the way I stopped doing that and just entered everything into my main binder. Below is a descriptive table of the participants who agreed to participate in interviews. There were many other service users (n=17) who were present during observation periods or who verbally consented to allow me to observe their meetings with clinicians during the times that I was shadowing the professionals. Only service users who agreed to participate in an interview were required to sign consent forms.

Service users (interviewed and participant observation)

Name	**Age**	**Housing**	**Brief history**	**Revenue**	**Language**
CHRIS	mid 60s	Subsidized housing	Service user since his early twenties when he had a 'psychotic break' after LSD while studying social work. With ACT for 5 years. No contact with family, limited friendships	Social assistance	French / French Canadian
TERRY	mid 40s	Independent apartment	Service user for 5-10 years. With ACT for 2 years. Very close relationship with mother, limited friendships. Previously married.	Disability benefits from employer	French and English / French Canadian
LIZ	Early 20s	Drug rehab centre and then institutional residence	History of heroin use, prostitution, living on the streets, since her teenage years. With ACT for over 2 years. Strained relationship with father, limited friendships. No	Social assistance	French / French Canadian

			other family contact.		
CHARLES	Late 30s	Room in a boarding house	Was previously homeless for many years. With ACT for 5 years. No contact with family or friends.	Social assistance	
ESTELLE	mid-30s	Independent housing	With ACT for 5 years. Has a close friend who accompanies her to appointments	Social assistance	
NATHAN	Early 30s	Subsidized housing	Many years of hospitalizations before recently coming to ACT (January 2014). No contact with family. Neighbour is only close friend/confidante.	Social assistance. Odd jobs under the table.	

Service providers (interviewed and shadowing)

The participating service providers included 2 psychiatrists, 4 social workers (including the team lead), 1 psychoeducator, 1 human relations agent with a bachelor is psychoeducation, 1 criminologist, and 3 nurse clinicians. For purposes of confidentiality, the pseudonyms I gave to participants will not be associated with either their professional background or their cultural background. This is acceptable because the specialized case management model of ACT does not prescribe certain tasks to specific professions (except for pharmacological injections and metabolic follow ups which are reserved for nurse clinicians).

Name	**Relevant or known work experience**
JOHN	Fellowship in 2005 in NYC with training in ‘street /urban psychiatry’. Also had training in community psychiatry.
RUBY	Recently completed fellowship at NYC in ‘street psychiatry’
CHRISTINE	Co-developed the ACT team starting in 2009
SUE	With ACT since 2009
DEAN	Specialized in housing support
KARL	Recent graduate. Replacing a maternity leave.

DEREK	Recent graduate
NÉOMIE	Previously worked with At Home research project
ANGUS	Previously worked with At Home research project
ANDREW	Started with ACT in January 2014. Previously worked at a primary care mental health team. Prior experience in corrections facility.
ALLISON	Worked in psychiatry for many years (decade +)
ROBERT	Worked in psychiatry for many years (decade +)

Data collection: participant observation, interviews, document analysis

The qualitative data collection methods used in this study included participant observation and semi-structured interviews with 18 individuals as well as reviewing service user files and internal program documentation.[58] Although this was a 7 month ethnography, *Christine* shared her thoughts on this stating *"c'est court 7 mois, un an d'observation serait souhaitable*". This was not possible due to personal time constraints and the nature of the doctoral program.

My ethnographic fieldwork began with 1 week of exploratory observation. During that week I recognized my role, at least initially, as an observer of social relationships that considers the subjective (recovery) and the intersubjective (citizenship) actions and interactions. In order to understand the bi directional role that community mental health teams have on the participants in their personal and social lives I initially focused my observations on how the service providers respond to service users and on the factors or themes that tended to guide or shape the relationships between individuals and between individuals and society.

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[58] At one point early on I considered focus groups with hospital patients to understand their experience but then decided that it would not answer my research objectives or respond to the theoretical framework. I also considered an interview with the peer support worker but since she still wasn't integrated into team (as of 2015 1 peer support worker integrated with team) I decided it wasn't relevant at the time.

Always referring to the initial research questions that are constructed in light of potential tensions and paradoxes amongst ACT and recovery, neoliberalism, and psychiatric practice, the observational research was conducted during formal meetings but also informal conversations on the hospital shuttle, in the streets, in the main clinic meeting room, and in the clinic hallways. I made sure not to always be present too often for their daily 11 am logistics meetings and over lunch, especially at the beginning; it is a close-knit team with strong cohesion and I didn't want to be too suffocating.

Semi-structured interviews and 7 months of observation have allowed for intimacy with the daily experience of the members of the ACT team. A qualitative methodology helped me get closer to the actor's perspective and through participant observation I softened the 'individualism' inherent in interviews. The participant observation included formal meetings and encounters with service users, service providers, and external partners (community and institutional) as well as informal encounters in hallways, doorways, and around the proverbial water cooler. I also paid attention to physical spaces and political and social activities implicating service users and service providers in the participating ACT team. Formal observations included observation of individual interventions, community interventions, team meetings, hospital admissions, emergency visits and community meetings. Informal observation included coffee meetings, grocery or clothing shopping with service users, and conversations in car rides, metro rides or while walking. Informal conversations are at a mid-point between participant observation and formal interviews. They were an important site of data collection, but also of ongoing analysis, as they revealed the talk, actions, and experiences that occur daily and spontaneously. These informal observations and interactions produced while driving or walking to a meeting are sometimes referred to as “mobile research methods” (Ferguson, 2014; Ross et al, 2009). They served to capture everyday movements and were instrumental in enriching more formal interview data and opening up space for honest and unceremonious dialogue. In this study, informal interviews conducted through mobile methods of walking and driving were with service providers mostly, but sometimes service users, on the way to and from home visits or to and from other institutional and community visits. The challenge was to identify these moments, and even create these moments through the development of trust and confidentiality, in order to formulate appropriate ethnographic questions and harness the richness in these exchanges.

During both interviews and observation time, the participants were encouraged to discuss their feelings and perceptions freely, allowing for the emergence of new ideas through dialogue. The questions changed as new dialogue emerged; it was an ongoing process. All the participants through various means of data collection were incredibly responsive to this and the data gained was extremely rich. I detailed my observations, ideas, and perceptions in order to contextualize and compare them to the statements made by participants. My notes from April 3, 2014 reflect on my methodological process as “a wave – there is an ebb and a flow. I observe, take a step back, do interviews, step back, go further, deeper now with information on which I reflected and observe some more.”

Notes

Systematic note taking during the participant observation process provided the principal data for this research and included detailed descriptive, methodological, and theoretical notes. These detailed field notes of daily events and interactions in the ACT team include not only the actions and discourses of participants, but also note my own role as well as the roles of others engaged with what is happening. I employed a general rule of saturation to the situations I observed. In other words, I made a point to observe and engage in informal conversations on multiple occasions for the same type of interaction or meeting. I purposely made sure to observe a wide range of situations, meetings, and encounters, and not only those that were initially thought to be pertinent to my bias and research questions.

The data collection phase of this project consisted of several different categories of note taking. I was inspired by Schatzman and Strauss (1973) in Mayer et coll. (2000) suggestion of three types of notes: methodological, theoretical, and descriptive.

I kept all of these notes in separate folders but in one large binder. This binder also included notes and reminders about the general objective and questions of the research (so that I did not veer too off track), formulas and forms collected during the study, and notes taken of the patient files that I reviewed. My descriptive notes included information about situations, conversations and activities, and observed practices. My methodological notes included a subjective account of my research experience. This is where I recorded not only my personal beliefs and biases, but also the observational choices I made. Finally, my analytical notes served as a place for ongoing and early field analysis, which often led to new or refined questions. These notes were vital to the data collection process and were almost always taken immediately or within one hour of observation.

Development of interview grill

This study also included individual semi-structured interviews with members of the ACT team, both service providers (medical and professional) and service users. Interviewing service users was particularly valuable because the research design designated the importance of taking into account the perspectives and experiences of service users. Also, the critical ethnographic perspective outlined above was particularly relevant to my personal impetus to ensure that the voice and experience of service users be included as central actors in the ACT team. The interviews examined the way in which participants relate to each other and to the institutions, the way they use the space in the ACT clinic, at the hospital, or in the community, and the meaning or understanding they have of recovery.

I am studying a public space (ACT team) that has different frameworks (Kleinman et al., 1978). Individual actors and particular groups have their own framework. The ACT space by nature necessitates the meetings of two or more spaces and frames of reference. It is for this reason that I used Kleinman et al.'s (1978) framing approach to guide the development of the interview grills and interview process.[59]

The interview guide was conceived with the objective of being flexible enough for participants to express their viewpoints surrounding five themes related to the research objectives. In order not to lead the participants in their answers, concepts surrounding recovery, their professional work, their personal experiences, and the ACT program were discussed without necessarily employing the term recovery directly.

It is important to note that two separate but overlapping interview grills were used – one for service users and one for service providers. The first step to developing the interview grills was to identify indicators, objectives, and then potential corresponding questions for the semi-structured interview. The indicators for each grill were the same – recovery theories, participation in the construction of practice, flexibility in the choice of approaches and types of interactions, community mobilization. For the service user interview grill I was also

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[59] The rational for this perspective was outlined in Chapter 3

inspired by an indicator and subsequent questions related to the process of recovery. The indicators, objectives, and questions were inspired by the literature review, framing theory, and my professional experience and they were constructed based on the research objectives. These initial indicators, objectives, and questions can be found in Annex 2. The interview grills are found in Annex 3 and 4.

The interview grill for service users was divided into 4 sections: 1. Personal narrative; 2. Arrival into the program – context, expectations, and welcome experienced; 3. Perspectives and expectations today; 4. Perspectives on recovery.

The interview grill for service providers was divided into 5 sections: 1. Professional narrative; 2. Portrait of service users; 3. Description of the ACT team; 4. Description of interventions and approaches; 5. Perspectives on recovery.

During the actual data collection, certain questions were excluded due to lack of relevance and others added due to continual analysis and literature reviewing; the process was organic. The interview guides were modified slightly following the first 2 interviews conducted with service providers. The guides for service users were followed loosely based on the discussions points that were most relevant and pertinent for the service user and also based on informal discussions that we had together prior to the interview. The interview questions were generally open-ended, allowing the participants to express and elaborate their responses as they saw fit.

I audio recorded every interview session and engaged a graduate student to type them up verbatim. However, I listened to the audio recording and read the transcripts several times during the study process. Although it would have been an incredible addition for the study, it was not possible to audio tape the team meetings, individual meetings, home visits, or informal conversations. The most important issue was the willing cooperation and complete comfort of the participants. One participant did change his mind regarding the extent of his participation during his hospitalization and although he consented to my presence as an observer he no longer wanted to participate in the interview process.

Finally, data collection was complemented by official documents internal to the ACT program and the hospital in which it is situated as well as documents from the *Centre national d'excellence en santé mentale* (CNESM), which offers evaluation and quality improvement advice to the different ACT teams in Quebec.[60] I studied internal documents such as: welcome letters, individualized intervention plans, recovery definitions. The analysis of these documents is helpful to understand the organizational frameworks and the orientations officially held by the institution. In addition, I was granted access to review patient files which offered information related to referral source to the act team, reason for referral, initial contact with the ACT team, and intervention planning. This allowed me to: a) corroborate information regarding service users that I got to know through observation and/or interviews; b) compare and contrast documented intervention practices with a larger pool of service users.

4.1.4 Analytical strategy and data analysis

The ethnographic component of this study meant that data collection and analysis were simultaneous. All field notes, observations, thoughts, ideas, and interviews were categorized under headings, sub-headings, and categories. Returning often to the raw data I had to decide how the categories related to each other. In ethnographic research data collection, analysis,

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[60] Using evidence based research results, the *Centre national d'excellence* supports the implantation and continuous quality improvement of its programs. Three main principles guide the consultants in their evaluations and recommendations: 1) the recovery of the service user; 2) the quality and continuity of services; 3) partnership and collaboration with community resources.

and writing up are distinct phases, but are inextricably linked – some data collection is needed before analysis can begin but all the way through I have been thinking about what I might present at the end. It is a model that looks more like a "spiral or helix, that demonstrates how analyses and writing up can lead back to more data collection and writing down" (O'Reilly, 2005, p.177). I worked early on in the data collection phase to sort out all my notes and observations, interview transcripts, and my memory of conversations and events into some sort of order that would be presentable to others. My research object, mental health recovery and the bi-directional actions and interactions between service users and service providers in tertiary care community mental health programs, was always in mind even as the research questions broadened and then pinpointed.

In order to prepare what I have discovered in a way that can be presented to others I began by analyzing all the data by sorting and exploring the things that I wrote down during the observation phase. As mentioned, things are never straightforward and linear. Analysis was very tangled up with every stage of the research process (O'Reilly, 2005). By that I mean that while I was collecting data and making observations I was already thinking about what I would do with it and how I would sort it out. I naturally was drawing on what I already know or I have learned through experience. That being said, my initial questions concerned recovery-oriented practice. But on the field as I was taking notes and conducting interviews I realized that my initial questions were not directly pertinent, salient or 'hot' for the participants or the contexts. The non-linear analysis approach allowed me to recognize that the problem statement must shift to respond to the reality of the field I was observing.

Through ethnographic fieldwork I was able to be flexible, to widen the reach of the research, and to change direction slightly in light of what I found out during my continuing analysis.

Mayer et coll. (2000) asserted that participant observation requires a consistent inductive method of data collection in order to engage in thematic analysis that is iterative[61], circular, and continuously adapting to emerging categories and connected relationships. Quivy & Campendhoudt (1995) signal the necessity to be attentive to the reproduction or non-reproduction of observed phenomenon as well as the convergence between different information obtained. In this way, they claim, the social and cultural order of the group being studied will appear more clearly.

Data analysis procedures

The beginning of the analysis was the flashes of insight I jotted down in my journal or in my observation binder. These emerged from my new position as an observer of mental health practice (as opposed to a practitioner) and from the relationship between myself, the data already collected, and the participants. Some observations (such as feelings of helplessness on the part of service providers) were taken back to the team lead to ask for feedback.

The next step I engaged in was to write stories for each participating service user and to start to identify emerging categories. I started by going over everything in a chronological order and then sorting it into thematic and descriptive categories using my notes, transcripts, and my memory to tell the story. Sorting helped me look at the patterns that emerged and give me the chance to link together themes that previously seemed unconnected.

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[61] An iterative process involves going back and forth between research design, data collection, and analysis

The third step included an exhaustive and systematic open coding phase (Peretz, 1998 as cited in Mayer et coll., 2000). During the course of the open coding phase I re-assessed my research objectives and realized that the most appropriate approach would be thematic analysis. Following the open coding phase, a preliminary coding framework was made with notes on possible emergent themes. This was refined and altered after discussions with my research supervisor; an overall structure for the codes was determined. I used Glaser & Strauss (1967) description of constant comparison method to guide my analysis. The first step, in which categories are discovered and incidents applied to each are compared, included placing the concepts, words, and phenomena that emerge from the content into meaningful and critical categories in an attempt to make connections between the categories. I read through the transcripts without apriori categories or a fixed conceptual framework and allowed for the emergence of themes. Strauss & Corbin (1990) define open coding as "the process of breaking down, examining, comparing, conceptualizing and categorizing data" (p.61). This initial open coding was tight, line-by-line coding that I inserted into a margin to the left of the transcripts and in my notes. I wrote 1-5 word sentences, often word-for-word (Julien, 2008; Strauss & Corbin, 1990), as I searched for critical terms, events or themes. After having marked transcripts and notes with codes in the margins, I used NVIVO technology to facilitate the attachment of codes to strips of data for the interview transcripts. This allowed me to retrieve all instances in the interview data that share a code (Coffey, Holbrook & Atkinson, 2011).

The second step of the constant comparison method is the emergence of core categories. It is at this stage that the coding process is referred to as axial coding (Strauss &

Corbin, 1990) in which code labels are assigned for themes without a limit as to how many. Some initial code labels included team structure, performance outcome measures, recovery, participation, housing, community contacts, symptoms management and medication, social network. The third phase is called selective coding which "involves scanning data and previous codes" (Neuman, 2003, p. 444). I found that the axial and selective coding phases were dynamic and even while I was writing the results chapters I was continuously making connections between themes and data, adding themes and dropping others, and reorganizing my analysis around core ideas. I used large poster boards to provide a dynamic visual of vertical and transversal components. The analysis considered micro-level dimensions of recovery, such as social interactions with friends, family and neighbours, meso-level dimensions, such as social interactions with professionals and institutions, and macro-level dimensions, such as community engagement and participation. The thematic analysis considered how smaller themes are embedded in the more prominent findings. I was interested in keeping the smaller themes marked on my poster boards in case these underlying issues were the ones that provided context and/or were connecting in a way that would underscore an invisible, but pertinent story.

The final stage in constant comparison method is writing the theory results, discussing the project, and discussing what is learned. I wrote this as both a story about this ACT team and as an intertwining web of narratives using many direct quotes from participants. I developed vignettes for each participant as a way to provide context for myself as I continued to write and analyze. These were developed using data collected through participant observation, document analysis, informal conversations, and interviews. The ethnographic aspect of this study supported this kind of storytelling, to impart some descriptive findings

(O'Reilly, 2005 p. 193). Geertz (1973, p.10) refers to this as the production of "thick description" of a culture.

Analysis of interviews

The inductive analytical strategy of constant comparison outline above was used not only to deal with data that is observed but not necessarily talked about, but also for dealing with data obtained in an interview. Regarding interviews, Mayer et coll. (2000) discuss the data analysis as the researcher's attempt to uncover relationships in the content of the data; in this case, the participant discourses. The data collection and analysis phase were carried out before a formal theoretical framework was defined. As such, although there were some concepts loosely defined for the purposes of the interview guide, I initially read through the data in its entirety in order to allow for the emergence of themes. While reading through I asked critical questions of the data related to recovery, ACT programs, and the relationship between service providers and service users.

This 'second stage' of analysis is also thematic and relates to what recovery is through the analysis of participant frames of reference. Inspired by Kleinman et al.'s (1978) explanatory model and subsequent work on the Explanatory Model Interview Catalogue (Weiss, 1997) I placed the concepts, words, and phenomena that emerge from the content into meaningful and critical categories in an attempt to make connections between the categories (Mayer et coll., 2000). These categories might include patterns of distress, perceived causes, help-seeking attitudes and behaviour as well as general beliefs about mental health/illness and recovery (Weiss, 1997). These categories were developed and delimited using the same strategy, and in a simultaneous manner, to analyzing the observational data.

4.1.5 Limitations, Reliability and Validity, Ethics

Limitations of this study

As with any study, limitations are present in this project. To begin, the study used a small sample size and was limited to one ACT team in downtown Montréal. Although there was participation by 100% of the service providers, both medical and professional (n=12), the service user participants represented less than 10% of the total number of service users with an active follow up in the ACT team (n=100). Nevertheless, the sample was adequate for this qualitative study and allowed for saturation of responses. From a critical constructivist approach, all phenomena are time and context specific and thus the question of generalizability is not a limit of the study since it should not be the aim of an inquiry that seeks the reconstruction of subjective perspectives in a specific context. The ethnographic methodology within the interpretative framework of this study leads to the analytic purpose of searching for meaning rather than searching for a generalizable scientific law (Geertz, 1973). However, the more moderate approach that I have adopted recognizes the possibility of generalization through the repetition of certain actions and interactions that lead to a broader set of features that could be considered recovery-oriented. This form of generalization is consistent with interpretive research of a culture that exists in the intersubjective field of meaning between persons (Lewis & Ritchie, 2003). As such, both the thick description offered in this study and the explorative nature of the interviews in this study are useful in not only understanding the context-specific culture of this particular ACT team, but in collecting data and observations as a basis for reflecting on the similar or transversal actions and interactions in other comparable contexts (other ACT teams in Québec and even other psychiatric services).

Another potential limitation is that the interviews, data collection, coding, and analysis were all conducted by one person, increasing the risk of bias. Mayer et coll. (2000) discuss the importance for a researcher to be vigilant with regards to possible bias that might be introduced in the data collection process (p.62). As aforementioned, my professional experience as a mental health social worker positioned me as a member of the 'in-group' with respect to the participants in this project. Even service users became more comfortable and trusting of me once they learned that "I knew what I was talking about". On the one hand, this ensured that the terms and language used during the interviews was not offensive and that it was easily understood. However, data collection and analysis can be influenced by my own subjective factors. It is important to note that objectivity and neutrality are not associated with qualitative research; thus, researcher subjectivity and influence is a limit of all qualitative research, but I tried to 'bracket' through ongoing and engaged reflexivity and an acknowledgement of my biases and beliefs.

Although a strength of this study is that it examined the actions and interactions amongst service users and service providers from multiple levels using a critical perspective and recovery-oriented approach, it is important to recognize that using other theoretical models, such as an ecological approach or structural social work perspective, could provide additional information that would be useful in understanding ways to increase the participation of service users.

Reliability and Validity

The reliability and validity of ethnographic research has been questioned (Lecompte & Goetz, 1982) but can also be assured through various techniques. First of all, let us remember that reliability refers to the ability for other people to redo the work and have a consistent language or result. Validity refers to the rigor and accuracy of the observations and data.

In terms of reliability and generalizability, ethnographic research is first of all a method that confronts the inherent subjectivity of all research through a continuous process of self-analysis and self-reflection. The pretention of objectivity is discarded for a more realistic acknowledgement that human actions, interactions, and discourses can never really be replicated. Using Lecompte & Goetz (1982), echoed in Laperriere (1997) and Mayer et coll. (2000) I attempted to approach reliability by addressing: my social role with in the research site and thus my ability to create alliances and obtain rich information (see Annex 1); how I sampled to represent diverse perspectives; the context of data collection which included observing many different meetings and conversations multiple times; clearly defining my analytical framework and theoretical perspective in chapter 3; providing a detailed research design and strategy in the present chapter.

Regarding internal validity, Lapierre (1997) and Quivy and Campendhout (1995) remark that the validity of observation depends on a continual confrontation between what is observed and other interpretative hypothesis as well as objective data. Practically, that partially meant that I validated thoughts and analysis by double-checking things with participants (ex. My observation of feeling of powerlessness, a lack of bureaucracy, paradox of the intensity of follow up and the goal of service user independence). I see research as a meeting with others wherein as a researcher I need to try and establish a dialogue with participants. I believe that it is through a respectful dialectical relationship that the researcher can learn and understand the lived reality of participants. In other words, validity in this exploratory, interpretive research project is partly ensured through the confidence that I established with participants (so that observations and interviews are human and humane). This is done through an attempt to construct a space with participants that is more equal. To do that I needed to acknowledge the power structures in place in my life, professionally, culturally and socio-economically (Jeffrey, 2004). Reflexivity and consciousness raising of my own positionality was a constant process during my fieldwork, an inherently personal experience. As Madison (2012) explains:

> “ … we bring our belongings into the field with us, not only the many others who constitute our being but how we belong to what we know, how our epistemologies are yet another site of our belonging with and for others.” (p. 10),

Through field notes and a personal journal as well as in dialogue with others (participants; research director; colleagues) I tried to maintain an awareness of my positionality and my values during my observations and throughout the analysis. I also found it useful discussing my day or my observations with a research-neutral family member because it helped me formulate my methodological notes. Moreover, I used a strategy of triangulation[62] of sources by employing three data collection techniques – participant observation, document analysis and case file analysis, and individual interviews.

In May 2014, after 5 months of observations and over half of the interview completed, I formally began initial analysis. I gave feedback to the team about my reflections and analysis up to that point. After the presentation, during the meeting that ensued, the service providers were very attentive to their posture and language. *Ruby* even caught herself in a moment of heightened awareness and adjusted her discourse and approach to describing a service user’s

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[62] Triangulation is a method of double checking the data obtained with multiple sources (Guba & Lincoln, 1985 ; Quivy & Campehoudt, 1995)

difficult mental health experiences. Other service providers, and *Ruby*, then said that with the additional information they were more aware of how they might unconsciously be interpreting their interactions using partial information and devising interventions based on those potentially biased interpretations.

In April 2017, when the results of the study were compiled and the dissertation near completion, I met with *Christine* in order to validate the entire project and discuss details regarding confidentiality.

Ethical issues

As discussed by Jaccoud and Mayer (1997) the question of ethics must be put forth from the very beginning of the research study. One major ethical problem occurs when participants are not informed that everything they say and do will be part of a research study. To mitigate this risk, I followed Creswell's (2014) suggestions to protect participants and ensure their understanding of their role as participants. Once participants were identified by the team lead, I met with them informally with another trusted service provider. If they felt comfortable[63] then I met with them again, either alone or with a service provider, depending on their preference. I explained the research objectives and how the data would be used. I reiterated this information as requested and always repeated it before the formal interview. Participants in the interviews signed a consent form (see Annex 5) that included a description and objectives of the study. They all kept a copy of the signed agreement. They were also

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[63] a total of 10 service users were referred to me for shadowing and interviews. Of those 8 agreed to participate. Of those 8, one person was hospitalized after 2 months of participant observation and retracted his consent to participate further in an interview. Another service user and I kept missing each other and a formal interview never took place. It is important to note that I shadowed an additional 11 service users who were not involved in the interview process. I also followed the document traces of several other service users (discussions about their lives and interventions in team meetings and through patient file reading)

informed that they could end participation in the project at any time. I also verbally requested permission for audio recording during the interview even though this was included in the consent forms. However, the written consent of people with whom I met on the street, on home visits, and in the hospital would have been a process that impeded the dynamic of the participant observation. It would have also compromised my attempts at discretion during observation. This was balanced by providing service users with a brief of my presence with the team for the 7 month duration of the study and by assuring verbal consent of my presence during any interactions. I worked with the team lead and the other service providers to develop a straightforward description of myself, my role, and the research as an introduction. However, given my past experience and my general comfort with the team as well as their open acceptance of my presence, the dialogue and professional understanding was such that if they needed or required a private moment with a service user non-verbal or brief verbal communication was sufficient for me to take a step back. In my field notes early on (January 21, 2014) I wrote about the challenge that my position as a clinician and researcher might have:

> "it is difficult as I get to know the team to maintain distance as a researcher. It is natural for me and the team, I think, to accept me and treat me as a fellow service provider. For example, I accompanied *Angus* to 2 home visits for the medication drop off. When he wasn't at the daily 11 am meeting to debrief the team on these encounter they looked to me for a mini-update on the service users in question."

The same applied for service users whose positionality I was especially aware of. Their comfort and acceptance of me was vital to the authenticity of this project. I was acutely aware of the power relations between service users and service providers and researchers. As such, I regularly used techniques such as 'checking in' and paid special attention to non-verbal cues to ensure that my presence was not harmful or unwanted. All service providers were provided with a brief summary of the research so that they might be able to answer any questions from a service user. I also worked to keep the dialogue open and authentic with the team and with any service user so that questions were invited. In my intensive accompaniment and observation of actions and interactions in the ACT team, I had to be very flexible and meld myself to the often changing, very dynamic schedule of service providers in order to integrate and access day to day interactions. When I experienced set backs and I was not able to show up I would advise the team. Understandably sometimes situations arose in which the service provider whom I was meant to shadow had to respond to a crisis and if I wasn't immediately available I would miss that opportunity for observation. Nevertheless, I had the chance to witness and record many events and unplanned situations. My presence with service providers and service users on the field was usually planned, but sometimes it was improvised. However, under no circumstance was my presence, and my role, anything but transparent.

The transcripts were made anonymous and both the written transcript and the recorded verbatim are stored in a secure location for seven years after which they will be destroyed. In order to preserve confidentiality all identifying markers of the participants have been deleted from the verbatim. It is worthwhile to note that I only used a recording device for the interviews. Everything else was transcribed by hand. The project was granted an ethics certificate from the University of Montreal as well as the Research Ethics Board at the participating hospital (Annex 6a and 6b). The data I collected through note taking was kept in a binder that was always either with me or in a secure location. It was not accessible to anyone but myself. The names of participants were coded from the beginning in order to maintain anonymity and confidentiality. The service providers were informed and accepted verbally that they might be recognizable based on the actions, interventions, and implication in certain meetings described in the final report.

Another important ethical consideration was the need for mechanisms to be in place in the event that participants become distressed when discussing their narrative or current life situation. This was mitigated in part by my clinical experience, ability to establish a therapeutic alliance, and mutual trust with the participating service providers. I had an obligation to explain to service users participating in interviews that as a professional social worker I have an obligation to declare certain situations such as a stated and planned intent to hurt oneself or hurt someone else.

3 - Results and Discussion

The voices of service users in specialized community mental health services such as ACT have largely been silent or unexplored and I was thus unprepared for the quantity and quality of “rich” data that came from the interviews with both service users and service providers. The greatest challenge I faced was with the management of the wealth of data and how to present and organize it in a way that would honour the lived realities of participants.

In presenting the findings I follow O’Reilly’s (2005) and Geertz’s (1973) model for an ethnographic study in which much of this first chapter (Chapter 5) is dedicated to imparting “thick” descriptive findings. This is because interventions, and ultimately the underlying value system that animates any practice orientation is deeply rooted in the organizational culture and context. The purpose of this description is also to help facilitate an understanding of Montreal’s urban ACT team for both insiders (research participants) and outsiders. The following two chapters (Chapters 6 and 7) focus on imparting an understanding of the relationships amongst participants and of the potential paradoxes of institutional accompaniment. Although the results in Chapters 5, 6, and 7 will be intertwined with some initial discussion points, in Chapter 8, an in-depth discussion of the results examines the role of this team structure as an interpreter and facilitator of a service user’s subjective recovery process. In short, using the lens offered by the concepts explored in the theoretical framework of this dissertation, Part 3 of this dissertation will explore the daily actions and points of contact of service users and service providers, and thus their interactions.

The intersubjective lens is one that I explored through the angle of citizenship. The results and chosen citations reflect a concern for understanding the space that is co-created in a therapeutic relationship (see Rodriguez et al., 2011) to decide together what is success, what is quality of life, what it means to be recovered, and what it means to be a citizen. As mentioned in the introduction of this dissertation, my approach considers personal transformations, political transformations, organizational transformations, and social transformations to be inextricably linked via our social structures. Thus, the results and ensuing discussion contemplates not only the ways in which overarching practice approaches, such as recovery, intersect with the organizational structure, but also reflects on the diverse perspectives of service user - service provider relationships. Part 3 of this dissertation highlights the intersubjective relationships of participants and the social scenarios that result in madness being a term or condition that is often defined by others and not necessary by one self.

The interactions in these relationships are perhaps determined by social structures (Berger & Luckman, 1966; Goffman, 1961) but are played out each day by individuals who don't just repeat them but also transform them. The following results chapters will present these structures and the people within them but also attempt to understand what the actors are producing and reproducing, what their relationship with the biomedical and recovery approaches are, and the space they have to produce new transformative relationships. The data analysis on which these results are based was completed through the lens of the questions of "has there been a renewal in institutional psychiatric practice through community care", and "are service providers and service users in conflict with what they want to do and what they can do", and "what does recovery mean for service users and service providers"? Although beyond the scope of this study, I couldn't help but dare to allow the larger macro question, "How do we create the social/the society that allows for recovery, citizenship, participation, and inclusion?", to remain in my conscience. In addition, I remind the reader of the ontological perspective guiding this research work (see Chapter 3), which is similar to that of many qualitative researchers in that these findings are an intersubjective product of the researcher and the research (Guba and Lincoln, 1994). Through intensive participant observation I can “shine a harsh light” (Peacock, 1986 in O’Reilly 2005) on the participants and participating ACT program in order to unearth the nuances, tensions, paradoxes, and processes of participation and accompaniment in the ACT team. Continuing with the analogy, I have also used a “soft focus” (Peacock, 1986 in O’Reilly 2005*)* afforded to me by the inductive nature of ethnographic research in order to follow the lead of participants, thus forcing me to adapt my focus toward aspects of ACT programs that I may not have considered at the outset.

The analysis is constructed around the clinical, political, and social space of the urban Montréal specialized community mental health ACT team. In this way it will explicate paradigms, constraints, knowledge, know how, and *savoir être*. The ACT program is a space that is meant to be more flexible[64] and specialized than other mental health teams and it is at the forefront of the paradoxes and controversies surrounding the recovery approach and citizenship movements in mental health. The experience of service users in ACT, a majority of whom represent a generation of people with mental health problems that have not lived in asylums, will transverse the presentation of results.

The following three results chapters are based on an analysis, described in Chapter 4, that considers micro-level dimensions of recovery, such as social interactions with friends, family and neighbours, meso-level dimensions, such as social interactions with professionals

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[64] The concept of flexibility and what it means in practical terms (e.g. outside of theoretical descriptions of ACT program) will be analyzed below

and institutions, and macro-level dimensions, such as community engagement and participation. As themes began to emerge, I recognized that the recovery approach and the concept of citizenship were not named by most participants but were invisible philosophies. That is to say, although they were discussed indirectly in a positive way, there were not prominent in the discourses and were variably present in action. The many barriers to recovery-oriented practice and to re-establishing citizenship roles for services users did emerge frequently in formal and informal conversations.

Chapter 5: Actions and interactions in the urban Montréal ACT team

In this chapter, a thick description of the urban Montréal ACT team will help to better understand the ACT program's role as a clinical service agency and potentially also as a political and social actor in the community. This description is crucial to the analysis and enriches the ethnography by providing crucial background information (O'Reilly, 2005). Although social realities are malleable and being created by social actors, as outlined in the ethnomethodological perspective, the social world, including politics and bureaucratic institutions, are more rigid. As such, based on an analysis of data collected during a 7 month period, this chapter proposes a description of the complex, negotiated, innovative, and local social relationships and social world that are not identified in traditional ACT fidelity scales. This chapter provides the specific context and description of that space and place using the information collected through participant observation and document analysis and supported by the interviews, by addressing the ACT team as a space and place wherein service providers and service users socially negotiate and potentially co-construct social actions and interventions.

The downtown Montréal ACT team, referred to as *suivi intensif dans le milieu* in French, is situated in the centre south section of the city. At the time of this research project it was responsible for serving clients living in the neighbourhoods of Ville Marie and Plateau Mont-Royal.[65] This neighbourhood is known for its intersection of complex social realities

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[65] Political and organizational changes in 2016 (Bill 10) resulted in the creation of supra-regional health centres and thus the ACT team is now part of a supra regional health centre that serves a territory covering 46 km^2

including homelessness, substance abuse, and poverty. The neighbourhood also presents an intersection of contradictions and paradoxes in its urban design and resulting social relationships: alongside poverty and social housing are condominiums that are only affordable to the very rich; next to a non-profit that serves lunch meals to a homeless population of men there are art galleries and luxury shops; the tranquility of city parks is peppered with the noise of honking car horns; and back alleys are a place for chic restaurants to throw out unwanted food which then become a meal for some of the service users participating in the research. As such, the ACT program, offering services to some of the most vulnerable and marginalized people living in this complex territory, represents a public space in which the intersection of psychiatric reform, mental health practice renewal, neoliberal economic policies, and the social and political roles of both service users and service providers takes place.

5.1 The urban ACT team in Montréal: a dynamic social space and place

This ACT team was constituted in 2009 following recommendations from the 2005 MHAP[66]. The MHAP required that the local service networks, *Centre de santé et des services sociaux (CSSS)*, develop mental health community follow up teams in collaboration with specialized care teams and community organizations. These community follow up teams, such as ACT, are considered to be the cornerstone of the MHAP.

5.1.1 The physical place and the space

On the 3rd floor of a building of a CSSS (*Centre de santé et de services sociaux*) at one of the busiest intersections of downtown Montréal, the participating ACT team has its office

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[66] The team lead at the time of this research, *Christine*, was selected by the parent institution in 2009 to lead the development of this ACT team and thus has a rich historical knowledge of the program and the team

space. Service users, employees, and visitors are greeted by a security guard and must then take an elevator to the third floor. When they exit they are met with a bright, spacious waiting room and two reception offices. The receptionists are behind glass panes. There is one receptionist for the ACT team and one receptionist for the primary care mental health team which is located at the other end of the corridor from the ACT offices. The doors to the ACT team corridor, situated behind the waiting room, are locked and can only be accessed with an employee I.D. card. Service users and visitors must present themselves to the reception and their arrival announced to the team. Sometimes, service users who are especially familiar with the surroundings and known to the receptionist will simply go straight to the locked door and knock. Usually these are the service users that have daily meetings at the clinic for medication or money pick up. Once through the locked door, visitors can expect to see meeting rooms on either side of the corridor. The first room on the left is windowless and painted in a light beige colour, as are all the other interior spaces. It has a computer in it and is typically used to help service users navigate employment, training, or housing websites. The room on the right contains a desk and chairs and has a window on the far wall. Continuing down the narrow but well-lit hallway, there are two offices to the right for the two psychiatrists, both of which have windows. Past that there is a large room that is the nurse's office and this includes two desks. The following room on the right is the medical room where the three nurses perform metabolic follow ups and administer psychiatric medications by injection. At the end of the corridor visitors will find the last closed office, belonging to the team lead. She is very often in the main room or on the road, meeting with or accompanying service users. The left side of the corridor, beyond the first meeting room, has two doors both of which open into what I have called the 'great room'. In this great room there is a large conference table and several cubicles. Each professional, other than the team lead and the nurses, have a designated cubicle. This great room also has a central workspace – many times service providers complete their notes at this central workspace or on the conference table. There is also a large white board with various bits of information scribbled on it – the name of a landlord that manages many buildings and apartments in which service users live, the day and time of the next team-building day or night out, a phone number for a cleaning service, etc… The microwave and a small table are below this white board. The great room is multipurpose: it serves as an office space, meeting space, and a lunchroom. There is another white board on the far right wall with the name of each service provider written on it. Under each name is the anonymous code for each service user assigned to them, along with the names of the 2 'back up' service providers, the treating psychiatrist, and the 'dream' that the service user has identified in the Individualised Intervention Plan (IIP). Only 9 out of almost 100 service users had a 'dream' noted beside their anonymized name. There is another smaller white board behind the conference table, opposite from this larger white board that indicates which services users are hospitalized in which admitting units and the date of admission. Again, their names are anonymously coded. Other than these white boards, there are no decorations or art placed on the walls.[67] At the far end of this great room is a doorway that leads to the file room and photocopy machine. All service user files are kept in alphabetized binders in a steel cabinet. Service users never enter the great room as they are seen in the meeting rooms (to collect their money or bus tickets, to look for employment, or take medication), in the psychiatrists' office (for regular medication follow up), or in the nurses' treatment room.

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[67] Following a 2 week mental health recovery seminar I attended in Brazil, I offered the ACT space a gift of a brightly coloured painting of Rio de Janeiro. This was hung on the wall below the IIP white board.

ACT's parent institution is a downtown general hospital that includes a psychiatric ward. The ACT program offers service users various outpatient interventions including medication drop off, follow up appointments, accompaniment to appointments and on errands, support in living in community based housing, and crisis intervention services, but it is the parent institution that provides acute inpatient care. This includes admission to the emergency room (ER) and intensive care units, as well as to one of 4 psychiatric admitting units. The 4th floor admitting unit is designated for service users who are waiting to be placed in some sort of institutional housing unit. Many of them have been living on this admitting unit for weeks or months. The 6th, 7th and 8th floors are regular psychiatric admissions units. Service users are placed according to age, with the youngest (18+) staying on the 6th floor and the eldest 60+ on the 8th floor. One of the ACT service providers and one of the ACT psychiatrists attend weekly meetings with the admitting units to discuss treatment plans for hospitalized service users. The service provider works closely with in-patient staff to develop treatment plans while an ACT service user is admitted. These treatment plans or interventions may range from denying privileges (service user must stay on the admitting unit floor), to allowing the service user to be accompanied to the hospital gym, to giving the service user a day pass to leave the hospital for a specified length of time and usually for a specific purpose.

5.1.2 ACT's positionality as a community-based team

Before exploring this ACT team's recovery-oriented community focus I will provide a clear understanding of how it is positioned with respect to the community and to its parent institution. The relationship it develops with community actors is contingent on how the ACT team is positioned by its parent institution and by the *Centre national d'excellence en santé mentale* and on how the actors themselves perceive it internally. My observations indicate that the ACT service providers consider their program to straddle both the institutional and the community sectors. However, they are employees of the institution and have strong professional ties to it. In fact, any resources or place that is not the hospital admitting unit is labelled 'community'. This might include housing (independent, supervised, group homes), community organizations, community places (coffee shops, restaurants), and community services (pharmacies, the police). Most surprisingly, other clinics that are community-based but tied to the hospital are considered 'community' such as the psychiatric outpatient clinics and the Variable Intensity Follow up (*suivi d'intensité variable, SIV)* team, and out of sector programs such as a substance use treatment program in Trois-Rivières[68]. All admitting units including the ER and the intensive care unit are referred to as the 'institution'.

Developing relationships with community organizations was discussed by the service providers as something that is difficult for ACT service users as *Allison* explained:

> *Je te dirais que dans tout ce qu'on a il y en a peut-être 10-15% [personnes usagères] qui fréquentent des activités communautaires, qui vont aller pour faire des activités communautaires… il n'y en a pas beaucoup [de ressources communautaires]. On leur propose, on les accompagne, ils vont avec nous une, deux fois. La seule personne qui vraiment a gardé ça c'est [xxx], c'est la seule qui fait des activités aux Impatients. Sinon le reste on a beau les mobiliser, les accompagner, ils vont y aller une fois et par la suite, ils sont découragés. Alors tisser ces liens avec les organisations communautaires c'est plus difficile*

However, another service provider, *Néomie* offered a bigger picture of ACT's position in the community and intimated that ACT's role with the community is to advocate, educate, and help ensure a better integration into life outside of the hospital:

> *…on travaille avec le partenariat parce que ça fait partie de notre mandat pour travailler avec le client mais on va aussi sensibiliser les partenaires à notre approche... Nous, on est comme là, les orateurs du* big picture *pour ces personnes-*

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[68] The service providers accompany admitted service users to and from this treatment program by car

> *là un peu. Comme au café c'est dérangeant mais si on est à l'intérieur, on essaye de 'voici nos coordonnés', on essaye qu'ils restent en logement le plus possible, merci de nous communiquer. Ou la police des fois, je vais leur faxer le plan d'intervention avec l'autorisation de la personne pour qu'ils sachent. Parce que ça change complètement la vision de la personne si on sait qu'ils sont en processus de quelque chose. Parce que des fois, ça a l'aire d'une finalité, ils voient juste une sphère. Les proprios ils voient juste le bruit à 11hr. Le rétablissement à l'intérieur de tout ça, je pense que c'est justement, nous on voit la ligne, on ne voit pas que la personne a juste un problème de santé mentale…*

This citation also evokes the invisible work done by this team that is well positioned to capitalize on the relationships they build with service users and on the opportunity the service providers have to singularly know each person. This will be presented and discussed in detail in the following chapters.

In the interviews, participating service users discussed varying relationships with community resources. One person said that his only contact with a community organization is "*Le CLSC de Mont-Royal…alors ils viennent me visiter pour des vaccins*" (*Charles*) whilst another service user frequented a soup kitchen daily and a community group for seniors in precarious or homeless situations. One service user explained how his social worker at ACT helped connect him with a number of community-based resources for volunteering and for therapy:

> *Il m'avait trouvé le Carrefour jeunesse emploi à Côte-des-Neiges, comme je te parlais pour l'aide aux devoirs. Il m'avait suggéré la Maison de l'amitié pour mon bénévolat en enseignement. Là ils ont essayé de le faire pour le suicide. Ils m'ont donné à peu près cinq références. La Maison Mon Bourquette, si jamais je retombe dépressif ou que je me questionne par rapport à mon père. (Terry)*

Another said that she is involved in many activities that she had to find for herself, without assistance or referrals from a service provider:

> *Ils veulent que je m'occupe là…C'est ça donc je vais dans des maisons pour femmes, ça s'appelle Chez Doris. Je vais à la Maison des amis, dans une église. (Estelle)*

Two other participants lamented the fact that they have no ties with any organizations or services other than ACT. One of them explained:

> *J'aurais juste besoin d'avoir du monde autour de moi et faire une activité. C'est juste l'aspect communautaire qui manque dans le fond…Des cours de théâtre, des cours comme ça. (Liz)*

The general consensus seems to be that the community relationships are lacking, specifically as they relate to leisure and cultural activities and connections. Service providers expressed the sentiment that the ACT program is alone and isolated in its efforts to maintain service users in a community-based living situation. However, it also seems that some service users are at the forefront of developing their own ties with community organizations and services and then bringing those resources back to the attention of the service providers.

Getting in and out of the ACT space and place

Getting to and from the physical ACT office space is facilitated by its downtown location near a metro station. Upon entering the building through the glass front doors, staff and visitors are greeted by a security guard. He knows most of the service users and I often saw him address them with a smile. Individuals who are known to the security guard are not questioned as to their business or destination and are free to use the elevator, located beside his small desk, alone. The space is wheelchair accessible.

However, access to the ACT space requires more than just being able to reach its physical destination. Becoming an ACT service user is not the result of a service users' request, but rather that of a referral from a psychiatrist in a secondary care team. As one of the psychiatrists stated in an interview

> *Alors c'est sûr qu'il faut s'assurer de prendre les clients qui ont besoin de [ce service] et de dégager les clients qui n'en ont pas besoin. Toujours, s'assurer qu'on a le pool de clientèle optimal du secteur qui a vraiment besoin de nous. À partir de ça, c'est là que je peux faire le travail de clinique de plus fine pointe dans tous les contextes (John)*

It is accepted by the ACT staff, and inferred through the referral process, that ACT services are meant to be a last resort. One of the service providers described ACT as 'the last hope' ("*on est le dernier recours*", *Karl*). When the team lead receives a referral she and one of the psychiatrists will visit the person (often in the hospital) to conduct a triage and assessment interview, to explain the functioning and purpose of ACT and what the program offers, and then to assess the team's capacity to take on another service user.

The ACT service model is not homogenous across the Island of Montréal – each team offers its own distinct perspective and approach. The specificity of this urban ACT team lies in the people who make up the team and in the people who live on the territory and are service users. This ACT program has a team lead who has chosen, and is sanctioned by the parent institution, to claim some autonomy on the intake process. She describes this process in the following way:

> *…je suis capable de faire une évaluation assez rapide quand je reçois la demande mais je ne prends jamais de décisions toute seule, je consulte les psychiatres. Des fois, je vais même allée me référer à l'équipe ou à quelqu'un de l'équipe quand je ne veux pas prendre cette décision là seule. De toute façon, il y a une évaluation toujours, ce n'est pas parce que j'évalue que je dis oui. Il faut quand même évaluer. Présentement, il y en a qui nous surprenne, il y en a que j'ai pris et je n'étais pas certaine. Des fois tu lis le dossier, et je me dis mon dieu seigneur, ça ne sera pas facile. Oui il est psychotique mais il y a toute la consommation, pas juste fumer un petit joint là, intraveineuse, crack, prostitution pour acheter la dope, en logement ça ne marche pas trop, paranoïde, trop méfiant, prend sa médication in and out. Des fois j'ai eu ces dossiers là…ça faisait peur et je me disais on va aller*

> *voir au cas où. Alors j'allais évaluer, écoute, c'est tellement surprenant. La personne est tellement surprenante. (Christine)*

This citation not only explicates the complexity of the social and medical problems facing service users in this ACT territory but also the professional uncertainty in the face of these complexities. More provocatively, it also alludes to values related to hope, respect, and belief in the potential of the person that are inextricably aligned with a recovery orientation.

In an informal conversation, one of the service providers also revealed differences in the intake criteria of ACT teams on the island of Montréal. She says another ACT team on the island refused a transfer because the service user was not taking medication. She calls this "terrible" (*"épouvantable")*. One service user, *Chris*, who was followed by another ACT team in Montréal, describes the differences in the two approaches. He explains that the other ACT team was very invasive and tried to shape him into a certain type of service user, whilst, according to him, this urban ACT team is more supportive.

> *Je ne savais pas à quoi m'attendre. C'est mieux que [l'autre] ACT, eux il me poussait dans le dos. Ce suivi intensif, ils t'accompagnent. Avec [l'autre] ACT c'est plus bang, bang, bang. Il faut que tu fasses ceci, ceci, ceci. Ils veulent te conditionner. Le Suivi intensif ici, ce n'est pas ça.*

Once the team lead confirms that the intake is happening, a specific service provider from the ACT team as well as 2 corresponding back up service providers (also referred to as the mini-team) and a psychiatrist are assigned. However, even with the assignment of a specific service provider, if any other team member wants to know a service user better the whole team is ready to include them in the follow up as of the initial meeting. In other words, this modality they have adopted internally is just one aspect of the 'specialized case management' in ACT. It is also an indication of the transdisciplinarity of the team wherein no territorialism or corporatism observed. Once a follow up begins, a therapeutic contract is signed by the service user (see Annex 7). This contract requires that the service user actively engages in her IIP, that she maintains an open line of communication with the team, and that she continues to live on the specific territory covered by this ACT team. For example, when *Terry* wanted to move to a less expensive apartment further north from his current residence, he was informed that doing so would mean the end of his follow up with the ACT team. Not wanting to lose his ties with his service providers, he chose not to change apartments.

Because ACT is a service offer of last resort conceived for service users who would not otherwise have the ability or capability to live independently in the community, the team described a lot of self-imposed pressure to maintain their caseload, rather than to refer service users out to a less invasive, less intense team. A service user can only have their file closed if the team and the psychiatrists decide and agree that she no longer requires services from this ACT team. Perhaps the most candid way to explain this process is through examples. On January 28th at a team meeting, the service providers talk about two service users who are described as 'stable' and are thus identified as possible transfers to the less intense variable intensity follow up team (especially given the pressure from the parent institution and the government to take on new patients). One of the service providers, *Derek*, later explained to me that they consider transfers to less intense follow up team within the parent institution after stability[69] of at least 1 year. The following examples illustrate 3 types of file closures. The first being that of a service user who is quantified by the team as 'stable' and not taking medication; the second is of a service user who is also 'stable' but considered more vulnerable

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[69] the meaning of 'stability' in the context of this team will be discussed in the next chapter. Briefly, it refers to the way in which the team determines and delineates clinical, temporal, spatial, and interpersonal stability.

because she is still taking medication; the third is of a service user who no longer wants her file open with ACT, but who is not considered ‘stable’ enough to terminate the follow up.

The first example is of a service user named *Christina* whose principal service provider was *Sue*. Because *Christina* was not taking medication and the team agreed that she didn’t need any, they discussed file closure with her. When *Christina* said that she wanted a follow up anyway to help with housing, relationships, and to have someone to fall back on, *Sue* referred her to a community mental health organisation called *Le Fil* that offers variable intensity community follow up. The psychiatrist made the file closure official by writing a closing note and another service provider, *Derek*, reflected that it was the first time the team had referred a service user our to a community organization (“*c’est la premièere fois qu’on réfère à un organisation communautaire”).*

For the second example, one woman, known as *Claire* was nearing the end of her treatment period with the ACT team. The team reports that she has been ‘stable’ for one year but the psychiatrist prefers to make transfers when there has been stability for at least two years. As such, the recommendation is to make the transfer slowly with close accompaniment so she doesn’t feel too disrupted (*“pour ne pas la bousculer”)*. *Claire* wants to continue her follow up with the ACT parent institution after her file with the ACT service is closed, but since she resides in another territory she will have to be transferred not just out of ACT but out of the parent institution. Because this is expressly not what she wants, the psychiatrist advises the team to prepare her well for this eventual transfer by giving her information and visiting the new hospital with her. However, several months later, in June 2014, *Claire* is transferred to the external psychiatric team at the parent institution based on her desire to continue her follow up in the downtown territory. One of the social workers on the ACT team accompanies

Claire to her first appointment with her new treatment team. Her specific service provider, who advocated for her during team clinical discussions, closely considered *Claire's* wishes.

The final example refers to the situation in which the team does not agree with the service user that her file should be closed. *Sara* is a service user whose follow up with ACT is predicated by a legal order that requires her to receive services and take medication prescribed by the psychiatrist at ACT and to live on their territory. In February 2014, her legal treatment order expired and the team deliberated as to whether or not to go to the courts to have it renewed. *Sara* explicitly told the team that she does not want a follow up from them, she does not want them to come to her house, and that she wants her file closed the day after the treatment order expires. Although the psychiatrist's initial impetus was to renew the order *Christine* insisted that *Sara*'s wishes be respected stating that "*tout le monde à le droit de choisir de prendre des risques*". She advises the team to become more comfortable with letting service users make decisions that they consider to be risky. Later, when we are in the parking lot about to go visit a service user, *Christine* explains to me that she often advocates this position because she is not scared of madness – "*je n'est pas peur de la folie, alors j'ai accès à la folie*". She hopes that her personal values, shaped by life experiences wherein as a young child her father welcomed marginalized and vulnerable people into their home, can have a positive influence on the rest of the team so that they may be more comfortable risk taking and tolerating different ways of living. Regarding *Sara,* the psychiatrist quickly conceded but refused to close the file officially. After 3 months, the team learned that *Sara* was involved in a car accident and sustained minor injuries in another city. The trauma of the accident affected her mental health and well-being. She was hospitalized and transferred back to the ACT team. When she again reiterated that she didn't want a follow up anymore the team responded with a suggestion from the psychiatrist: they told her that she could accept the follow up willingly, or that she would be forced to receive a follow up and medication through a renewed treatment order.

In contrast to this last example is the situation of a service user named *Joe*. *Joe* was frequently leaving Montréal and subsequently being hospitalized for mental health problems in other regions of the province. Most recently, he was hospitalized in a region several hours away. The hospital in that region called the ACT team in order to transfer him back to Montréal. However, *Joe* said he did not want to live in Montréal or have contact with the ACT team. In this case, the psychiatrist's opinion was that,

> *il veut faire sa vie comme ça. Quand il vient à l'urgence il est bien,* crew cut*, bronzé, bonne hygiène, pas de dangerosité … Le traité par force est pire de ne pas le traité*

and thus if he wants to be seen by the team they will help him out but they will not reach out to him and thus remain uninvolved clinically and socially in his life.

The above examples offer a glimpse into the many paradoxes, contradictions, strengths, and weaknesses of this team with regards to their actions and interactions with service users. It also exposes the team's closeness with the singular experience of each service user. In short, these examples offer an indication of the different relationships with 'madness' held by the multiple actors in an ACT team. I will begin to explore this relationship in this chapter, whilst describing and getting to know this ACT team. I will do this specifically by 1) providing a thorough explanation of the organizational structure of this urban Montreal ACT team; 2) describing the structuring role of medication.

5.2 The organizational structure: what happens in the ACT space?

To recapitulate, the objective of the ACT teams in Québec was closely aligned to the objectives of ACT teams outlined in American contexts. That is, to provide comprehensive outreach in the community where service users can access the same type of treatment team they would have if they were in an inpatient unit (Bartlett & O'Connor; G. R. Bond, 1991; G. R. Bond, Drake, Mueser, & Latimer, 2001; McDonel et al., 1997; Phillips et al., 2001; Teague, Bond, & Drake, 1998). This stated objective in the ACT literature has been understood and embraced by participating service users who state that the *raison d'être* of the ACT team is to help services users in their daily life ("…*aider les patients et patientes dans la vie de tous les jours*", *Estelle*) in it's function as a hospital without walls ("*hôpital sans murs*", *Terry*). *Chris* believes that the ACT team is there to help him avoid recurrent hospitalizations:

> *le Suivi intensif c'est pour me maintenir loin du cercle infernal des hospitalisations. C'est très humain. Ils sont très à l'écoute de nous, ils sont très respectueux*

Meanwhile, *Charles* invoked the expanding mission of an urban ACT team and the intersection of social problems such as poverty and homelessness. He explained :

> *La raison d'être du Suivi intensif c'est de s'occuper des gens qui ont de la misère à se gérer eux-mêmes, des gens avec des problèmes mentaux, c'est des gens qui sont sujet à retourner dans la rue finalement. Donc si on ne nous aidait pas, peut-être qu'on aurait des problèmes au niveau du logement*

Service providers also largely concurred with the prevalent literature. They agreed that the definition of ACT as an intensive, community-based follow up offers service users the opportunity to live independently and eventually, autonomously:

> "*d'avoir un appartement parce qu'on est là, on peut aller les voir à tous les jours*" (*Sue*); "*le but ce n'est pas de les assister toute leur vie, c'est vraiment des outils pour les rendre autonomes*" (*Dean*), " *[on est] un filet de sécurité aussi qui va*

> *veiller à ce que leurs besoins fondamentaux soient comblés, qu'ils ne se mettent pas en danger, qu'ils ne retournent pas à l'hôpital trop souvent…*" (*Andrew*).

However, all of the participants also provided a nuanced and flexible perspective of their role within ACT and on the place that values have in their daily actions and interactions. The ACT space is both the place for actualizing a community-based, specialized mental health service offer and a space in which actors, service users, and service providers, are nearer to the social and political realities that affect their lives and their interactions. Their actions, interactions, and discourses illustrate a myriad of tensions that challenge common or shared ways of doing things. This includes processes of participation and of exclusion as well as potential for and the acting upon collective action and political influence. Now that the reader is familiar with the physical ACT place and space I will turn to the specific activities that unfold within this space.

5.2.1 Meetings with service users

The daily atmosphere in the ACT team was one of controlled chaos. That is to say, each day held an unexpected event or situation. Yet the team worked together in a seamless and respectful nature, which belies their trust and confidence in each other. Although peppered with spontaneous events usually regarding a service user in crisis, most days included appointments and planned meetings that I have placed into 4 categories.

Med drop

The first and most predominant type of meeting is the *Med drop*. A *Med drop* is the name given to the daily, and sometimes twice daily, brief meetings in which service providers drop off medication at a service user's home. For some service users, *Med drop* only occurs a few times a week. For service users judged by the team to require more surveillance, *Med* *drops* can be twice a day. Also, the team decides if all they need to do is hand over the medication to the person, or if that person is obliged to actually take the medication in front of them.

Sometimes, *Med drops* opened the door to conversations regarding the intensity of the follow up. For example *Isabelle* wanted 2 *Med drops* per week instead of 5 times per week. Her principal service provider determined that "she's doing well" ("*elle va bien")* and so the team agreed to try this new schedule at her request. However, in another example, *Melanie* was often missing *Med drops*, either because she forgot or because she did not want to wait in her small apartment for the service provider to arrive. As a result the team agreed that she would be told to be home from 4pm to 5pm daily to receive her medication otherwise they would obtain a court order to enforce pharmacological treatment.

Regularly the team lead would revise the *Med drop* schedule and assess with the team if the frequency and intensity of visits corresponded to the their assessment of the service users' needs. Sometimes, but not always, this considered the expressed wishes of the service users although they did not regularly prompt the service users for their opinion on the subject.

The place that *Med drop* takes in the lives of service users and in the work of the service providers cannot be underscored enough. Many service users, such as *Chris* were frequently upset with the timing of the *Med drops* as the service provider was often late and his daily schedule was interrupted by having to wait for them. Many of the service providers expressed a discomfort or even dislike of the technical aspect of med drop, with one service provider summing up the sentiment of most of the psychosocial staff when he stated: "*Il y a du med drop en tabarouete"*. However, the service providers seemed to reconcile this task by using the opportunity to check in with the service user and effect a brief and informal evaluation of their mental state and well-being. The result seems to be numerous medication compliance-focused interventions paradoxically offered hand in hand with a specific recovery philosophy that is constructed to be coherent with the program's goals and position. I discussed this informally with the team over lunch who said they try to work with recovery, but there are so many crises that it is difficult. One service provider succinctly explained the way recovery is tied to the *Med drop* interventions:

> *le rétablissement est la fondation du suivi intensif. On ne pourrait pas justifié donner des médicaments à chaque jour chez les personnes sans ça (Néomie)*

This echoes the perspective of many of the service providers, whose understanding of recovery is framed within a certain normalization of coercive psychiatric practices. This will be discussed in further detail in Chapter 6.

Follow up meeting

These are meetings that usually take place 'in the community', that is at the service user's home or in a café/restaurant. This is not therapy; these are check-in meetings that last 15-45 minutes. If a person needs therapy (such as *Terry* for grief counselling or *Sasha* who is seeing a psychoanalyst in private practice) they are referred elsewhere. One service user, *Charles,* described these appointments in this way:

> *Disons que ça arrive à l'occasion qu'on aille prendre un café et puis on discute. À part ça, quand ils viennent me voir dans la maison de chambre, c'est des jasettes finalement. On ne planifie pas quelque chose d'important. Ils voient le fonctionnement de ma personne à moi.*

Two of the service providers, *Sue* and *Derek* explain that because the team is always in the middle of the action and intervening in the 'the here and now', there is no time for therapeutic approaches that require longer meetings. They also don't complete psychosocial evaluations or psychoeducational evaluations.[70] They say these evaluations are not necessarily pertinent because the duration of a follow up with ACT is over the course of several years and because they meet as a team everyday to discuss service users and make decisions on interventions.

Most follow up meetings take place in the service user's home. For service users such as *Terry*, the team agrees that a cap of 45 minutes must be established as he has a tendency to want to talk and share more than they think is appropriate. These follow up meetings might be justifiably longer when there is an Individualized Intervention Plan (IIP) to complete. Although these IIP prompt the service providers to ask service users about their dreams and hopes, mental health recovery as a concept or as a personal journey is never discussed. In June 2014, towards the end of my fieldwork observation period, I asked a few of the service providers if they thought that meeting service users in their home is counter productive, in that they not really integrating in community. The responses varied from "I haven't thought about it that way before" to "I am not sure that integration is part of the reasoning for the follow up appointment".

Meeting in the ACT office space

These are brief meetings taking place in one of the meeting rooms in the ACT office. Some service users prefer to come to the ACT office in order to pick up their medication a few times a week. *Estelle* is one of these people who says that going to the office forces her to get out of the house and see other people ("*ça me force de sortir de la maison et voir du monde*").

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[70] A professional notice in 2017 from the OTSTCFQ, the professional order that governs the practice of social work in Québec, and the CNESM explicated the necessity and the legal responsibility for social workers practicing in ACT team to complete, in some form or another a structured and traceable assessment of social functioning report.

Other service users, such as *Nathan*, are visited at their homes daily for *Med drop* and then also come to the office a few hours later to pick up part of their money as per the budgetary contract they have with the hospital Trust. When discussing the particular case of *Nathan*, three service providers (*Sue, Derek, Christine*) conclude that his personal and home hygiene needs to be improved. They have already engaged a cleaning service and supported him in learning to use the washing machines in his building. However, his hygiene is still not adequate, according to the team, and so, not finding any other recourse, they consider using money or controlling his money to get him to wash and shower more often. Because he goes to the office 3 times a week to collect money, and often asks for an extra $20 to pay off debts, the team feels that this is a possible lever for ensuring adequate hygiene. The use of money, food, and other proverbial carrots as leverage will be exposed throughout this dissertation. Both the positive and negative consequences of this kind of influence in relationship building will be discussed in Chapter 8.

Meetings in the office also occur when service users have scheduled appointments with nurses for metabolic follow-ups or to receive injectable psychotropic medication. Other scheduled appointments might be for help looking for work or school (Individual Placement and Support services with *Dean*) or for a psychiatric follow up. These psychiatric follow-ups are medication and symptom focused. As explained by one of the service users:

> *Mon docteur…moi je trouve que ce n'est pas pareil comme je m'y attendais… mon psychiatre ne me pose pas des questions comme ça. Il attend que je lui demande. En général, je lui demande de changer mes médicaments et ça fini là. (Liz)*

Accompaniment and network/community follow-ups

This category of follow up includes any action or interaction between service users and service providers, or community partners and service providers, outside of the ACT office.

These can be very rich and often create a sense of intimacy and trust between actors in an ACT team. For example, *Angus* told me that he likes to visit service users one on one and accompany them to do groceries or go clothing shopping. He says that this is more informal than one on one follow up meetings or *Med drops* which become boring and routine for him as a service provider. These accompaniments can happen when visiting housing, going for non-psychiatric medical visits, or visiting a community organization for activities. Generally, perhaps because they are outside of the institution and are not formal, service users also appreciate these interactions:

> *On est allé faire la carte d'assurance maladie et la photo de la carte d'assurance maladie. Dans la communauté il y avait une couple d'épiceries…C'est naturel. C'est un évènement qui est normal de sortir pour faire la carte d'assurance maladie (Nathan)*

The accompaniment of service users in attending to daily life needs, or 'normal events' as stated by *Nathan* is a privileged space in which service providers have the opportunity to create dialogue, build relationships, and understand the singular experiences of the service users.

5.2.2 ACT Team meetings[71]

In the great room of the ACT office space service providers gather for team meetings. The team structure is one that does not have an over-reliance on psychiatrists for decision making; I only see them once a week at the weekly team meetings. They are present at other times for individual follow up meetings or at weekly meetings with the hospital admitting

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[71] I decide to observe at least one team meeting per month and any 'special meetings' in order to have a good sample and not be too obtrusive to the team. I observed 2-3 11 am 'logistical meetings per week. On my first day of exploratory observation with the team I attended a team meeting. The team was very generous in explaining to me their history and their modes of functioning.

units, but unlike the other service providers they rarely linger and engage in informal conversations. The decision making process of the team is flat and non-hierarchical.

Every Tuesday afternoon there are team meetings with the psychiatrists and every day at 11 am there are 1 hour meetings with the service providers to touch base and update each other on all 100 services users. Service users are not included in collective decision-making or advisory discussions. During these daily meetings, service providers are updated on every single service user on the team (2-3 minutes per service user, this is not a lengthy clinical discussion). Updates include items like service user living conditions (furniture, heating, infestations); hospital and administrative issues related to upcoming discharges and discharge planning/housing options; medication issues, cravings, managing medications prescribed as *pro re nata*[72]; socialization, family contacts, feelings; medical follow up; any changes required to the intensity of *Med drop* visits. They decide upon schedules and medication drop off routes. This includes deciding who will be the shift manager the following day. The shift manager holds down the fort so to speak and greets any service user who shows up at the clinic (scheduled or unscheduled) for money, medication, or other issues arising. The choice of shift manager for the following day is done collegially and by rotation; the person assuming the role of shift manager changes every day. The shift manager does not go out into the community and thus does not do have follow up appointments or deliver medications.

They also take the time to coordinate schedules (ex. Determining who is on night shift[73]). These meetings are very democratic following the structure of a flat organization where there is no obvious boss or lead. However, upon deciding who visits which clients and

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[72] Also referred to as PRNs, or medication to be used as needed and usually self-administered by the service user

[73] ACT is supposed to be a 24/7 service. To fulfill that, the person on night shift goes home with a pager and can be contacted by the ER, police, supervised housing, etc…in the case of an emergency.

when, the team lead makes the final confirmation of the *Med drop* route and strategically places service users in order according to their address and the most efficient path for the service provider to take. Some issues that take too long are tabled to be discussed at a later time by the 'mini-team'. If a service provider is not present (usually because she has a meeting with a service user) then someone else will take notes for her on any changes or on what she needs to do with her assigned service users. The shift manager runs these meetings and works through each service user update by reading out their names in alphabetical order. These are kept on a sheet in a binder called the Kardex (see Annex 8 for a blank example of Kardex sheet). The Kardex includes all of the service user names and each individual sheet includes relevant information such as assigned service providers and mini team as well as diagnosis, IIP objectives, date that the IIP has to be revised, interests, pass times and interventions to privilege as well as particularities. I noted that the Kardex was rarely fully completed nor is it updated because of the very fast paced environment of the clinic and the fact that most of the knowledge or information is communicated orally amongst service providers with a slight delay in writing it down

Once a week they have a larger and longer clinical team meeting with the psychiatrists. The team lead begins every weekly team meeting with weekly 'wins[74]' and the structure of the meeting is as follows: wins, review of recently completed Individual Intervention Plans (IIP), clinical discussions of issues and problems with the psychiatrists who offer their input and perspective. These team meetings are described as follows by the team lead:

> *On parle des vraies affaires avec les clients, on fait des PII, on parle de ce qu'on fait ce qu'on ne fera pas. C'est une portion qui est assez croquante pour moi parce*

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[74] That might mean success with an intervention or another positive aspect brought to the team or to a service user.

> *que des fois il y en a qui ont le gout de baisser les bras et c'est à moi d'avoir ce regard là de dire est-ce qu'il y a encore quelque chose à faire? On travailles-tu avec l'espoir? C'est quoi l'objectif? À qui ça fait la différence, à moi ou à l'autre? Je ramène souvent les gens à : Pour qui je le fais et pourquoi je le fais. (Christine)*

I notice as of my first day of observation that the team is not rushed during their weekly team meeting. They take their time to discuss events, concerns, clinical impasses as well as positive interactions with service users. The specificity of the ACT team meetings and daily logistical meetings lies in the place, space, and time that this team allows for clinical discussions. In other words, they give themselves flexibility and time to communicate with each other and in turn with the service users.

There are actions and interactions, understandings, requests, conversations, and certain expectations of roles and relationships amongst the various actors in this ACT program. These include social workers, nurses, psychiatrists, psychoeducators, criminologists, young service users never having lived in asylums, older service users with a long history of psychiatric care, homeless service users, service users on social assistance, service users in school or at a job, service users taking drugs. In order to fully understand them we will continue with an overview of social roles and social relationships observed in this ACT program.

5.2.3 Daily office happenings – roles and relationships

The great room is seen as a sacred 'safe space' for service providers to connect, share, and debrief not just during formal meetings, but informally as well. When service providers are not meeting with someone they settle in at their desk in the great room. Their note taking and administrative follow-ups are peppered with discussion and gossip on personal matters.

For example, on January 20th two service providers were advising another service provider on the purchase of a condo he was intending to make. This demonstrates a closeness and camaraderie on the part of the team, which proves to be necessary when difficult decisions need to be made or when organizational changes cause an upheaval in the team. The staff always eats together in the great room and during that time the phone and the door are not answered.

In the mornings before the 11 am meeting, staff do what I call their ‘early morning round up’. They exchange stories from the evening shift, gather feedback from each other in a collegial and non-judgemental manner, and release tension through jokes and personal anecdotes. There are several examples of this in my observation notes.

On February 3rd *Robert* told a story of a service user that he says is starting to have delusions again and who asked him to kiss her forehead. Everyone chuckled at this image of him kissing this woman’s forehead and then they unceremoniously moved on with their note writing, phone calls, and office meetings with service users. This early morning period is also a time for ‘getting things off the chest’. For example, on the morning of February 4th *Karl* came in and immediately discussed a difficult intervention he just had which was followed by a surprise encounter in the waiting room with an ACT service user and her partner. He relayed his clinical opinion that the service user was in a manic phase of bipolar disorder. This service provider, who is the newest addition to the team and a young and relatively inexperienced service provider, seemed to be both excited, almost on an adrenaline high from this unexpected meeting, but also frustrated. The safe space created in the great room to discuss these things was helpful for him to be able to reflect, analyze, and move on with his day. Another service provider, *Derek*, also shared a difficult intervention one day in this early morning roundup. The service user in question was hospitalized but ran away from the admitting unit. He returned to his mother, whom he has physically aggressed in the past. He emptied his bank accounts and bought himself a bb gun. The service provider found out because the service user's mother came to the ACT office with a bag and proceeded to put the gun on the table. He said he's never seen one before so his adrenaline was very high and he immediately consulted his colleagues. The service user eventually returned to the hospital (in fact he had intended to return with the gun, which frightened *Derek*) and was placed in intensive care. Sharing this story with more experienced colleagues helps each service provider gain perspective and a sense of calm. For example, during the above scenario some of *Derek*'s colleagues shared advice or perspectives that are entrenched in a strictly medicalized solution by telling him that the service user simply needs a change in medication. Other colleagues responded with empathy towards the service user's actions stating "*he must have been very scared to buy a bb gun*" and some colleagues responded with an impetus to accompany *Derek* with a sense of teamwork and collaboration: "*next time, call me if you are scared and I will back you up*". A final example of the complex situations that are faced by the service providers before 11 am each morning involves a nurse, who previously worked in a primary care mental health setting and in a correctional facility. His approach is always very calm, balanced, and empathetic. He also shares a morning *Med drop* story in which a service user refused medication. Because he is new to the team he still asks for and is offered background information on different service users. The team informs him that this particular service user has a treatment order and thus is not allowed to refuse medication. Together they deliberate on how to explain and eventually force the service user to take his medication. The conversation is continued in depth during the afternoon's team meeting where the team agrees to go see the service user in a pair tomorrow morning to explain the consequences of not taking his medications. During the team meeting *John* suggests that it is worth putting the treatment order into effect immediately – essentially requiring the team to call the police and have the service user escorted to the psychiatric emergency room in order to receive medication against his will - to ensure medications are taken. However, the psychiatrist respects the rest of the team's desire and decision to delay this more traditional knee-jerk reaction and he agrees that he will see the service user at the office later in the week.

Typically there will always be at least one nurse at the office, one shift manager, and any other service provider who is not currently meeting with a client. There are 2-3 service providers dedicated to doing the *Med drop* route every morning and every evening; this may take several hours. When service providers are at the office they are meeting with service users who come to the clinic for their money, for a bus pass, for medication, for an IPS meeting with *Dean*, for metabolic follow up or clozapine follow up with a nurse or for a meeting with the psychiatrist. Sometimes service users will meet up with service providers at the office before heading out to see a new apartment, meet with the pharmacist, go grocery shopping, go clothing or furniture shopping, visit an organization in the community or head to another appointment together. Often service users will call with specific needs. For example, on January 20th a woman called because she was sick and needed a new RAMQ. *Derek* spoke to her and told her that the social worker will have to complete the necessary forms. He tells her which service provider she can expect to see in the afternoon and advises her to call 911 if she is really not feeling well. The shift managers are generally very kind and patient on the phone and take their time with people who call or come to the door. However, there are exceptional circumstances. One team member expressed a lot of frustration and even anger toward a service user, *Olivier* who was recently hospitalised. *Olivier* called the team repeatedly to find support for his concerns regarding his hospital stay. As shift manager, *Karl* answered the phone every time, and every time expressed more and more irritation toward *Olivier*'s requests. Finally he threatened *Olivier* with the removal of his telephone from his hospital room. However, once the psychiatrist returned to the office and they debriefed, he quickly informed him that he could not make such threats, calling the proposition "illegal" and helped him understand his frustrations. The psychiatrist and the team offered *Karl* suggestions on how to manage the multiple calls, such as asking *Olivier* to collect his questions and call only 4 times a day. This is evidence of trust and openness amongst service providers and underscores the important role of supervision.

In addition to the transdisciplinary, integrated team organization, there is an important intersectorial component to their work as they are in daily contact with police, organisations such as Old Brewery Mission (OBM) and Bon Acceuil, local landlords and other hospital services. This ACT team is transprofessional wherein "disciplinary boundaries are partly dissolved" (Thylefors et al., 2005), the expertise of each discipline is transmitted to other team members so that knowledge and terminology from many disciplines (psychiatry, nursing, social work, criminology) is incorporated into the discourse and actions of all team members. The literature points to the supportive role that this can foster within a team whilst also underscoring the potential risk that some "team members may not realise the value of the contribution of others…and not use their expertise to the full" (Mariano, 1999 as cited in Thylefors et al., 2005). A theme in the interviews with service providers is the statement that ACT offers a flat team structure with no hierarchy. Professional distinction isn't important;

generally, their role as case managers and not their profession determines their actions and interventions. This is well articulated by one of the social workers who is also in charge of the IPS program:

> *On n'est pas juste TS, on est un petit peu infirmier, un petit peu psycho-éducateur, un petit peu cuisinier, je dirais presque. On fait de tout finalement. Mais chacun de nous a sa propre identité. Ça c'est important ça. Mais c'est vrai qu'en Suivi Intensif c'est particulier parce que des fois on déborde par rapport à ce qu'on fait aussi. On déborde sur nous aussi par rapport à ce qu'ils font. Je ne sais pas si je me fais comprendre. Donc c'est sûr que c'est vraiment de prendre sa place sans trop empiéter sur l'autre. Chacun fait pratiquement le même boulot avec ses propres gestes attitrés (Dean)*

Very little professional hierarchy is observable during team meetings, logistical meetings, informal conversations, and during individual follow up sessions. If a final logistical or clinical decision had to be made, all professionals deferred to the team lead, a social worker. Despite the ubiquitous biomedical paradigm, the medical professionals demonstrated a lot of respect for the professional opinions of every member the team and offered a large space for clinical and administrative decisions to be made in a collective manner. Many aspects of work organization are supported by this transdisciplinary team approach. For example, the psychiatrists will never see a service user alone. I observed meetings with service users, their assigned service provider, and the psychiatrist. The service provider was consistently available as a support person to the service user and not necessarily as an accomplice to the psychiatrist. Once I sat in during a meeting with *Estelle,* a service user, *Néomie*, a service provider, and *John*, a psychiatrist. *Estelle* was experiencing negative metabolic effects with her current medication and *John* explained the options. The service provider always addressed *Estelle* directly and supported her in asking important questions. *Néomie* would say something like "do you think it would be important to find out more about the side effects of the medication he's proposing?". In fact, service providers call both of the

ACT team psychiatrists by their first names[75] ; I observe many instances of dialogue and respectful disagreement amongst the psychiatrists and the professional service providers. During these instances the professional's opinions and intervention suggestions are often pursued, even when they differ from the psychiatrists' opinion. This is evidence of the latitude that professional service providers are given in constructing interventions and may account for their autonomy and confidence in offering intervention options. For the psychiatrists, this process is central to their vision of ACT as a recovery-oriented service:

> *le Suivi intensif c'est un véhicule de réadaptation et de rétablissement. Le traitement est secondaire dans le sens que c'est un préalable souvent pour qu'il y ait un processus de réadaptation et de rétablissement qui fonctionne bien, mais ce n'est pas le cœur de notre action. En fait c'est un élément essentiel mais qui ne devrait pas utiliser beaucoup de ressources. Donc je suis là pour établir le traitement, faire l'évaluation pour établir un traitement et le traitement est là pour qu'un processus de réadaptation puisse se mettre en place. C'est pour ça que je ne vois jamais les patients sans intervenant parce que pour moi de faire le traitement indépendamment de la réadaptation, ça n'a pas beaucoup de logique, pas beaucoup de sens. Ça va toujours être pour améliorer les symptômes, diminuer la souffrance, d'accord, c'est la dimension médicale mais ça c'est pour que quelqu'un puisse s'inscrire dans un processus pour améliorer sa situation. Mais donc à ce moment-là, pour moi ça va toujours de faire avec l'intervention que font les autres intervenants, les autres personnels de l'équipe. Souvent, l'équipe va me faire voir un patient parce que justement le processus de réadaptation semble un peu bloqué ou interrompu et il peut y avoir des rapports médicaux dans le sens que la maladie est déstabilisée ou ça peut être d'autres enjeux relatifs à la personne. Qu'elle n'est pas prête ou elle a peur d'avancer. On peut voir ça de différentes façons. À ce moment-là, je me positionne pour essayer de remettre sur les rails le processus de réadaptation, de rétablissement. On redonne de l'énergie à cette idée qu'on n'est pas dans du maintien ou de la stagnation mais on veut que les gens avancent, progressent, franchissent les étapes un petit peu.*

This is important because it creates space and potential for different ways of intervening and relating to service users, sometimes outside of the medical or biomedical guidelines. The team is also afforded substantial space to remain clinically focused without very much time or

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[75] My previous work experience in many different psychiatric teams both in clinical and research demonstrated clear hierarchal differentiation including referring to team psychiatrists exclusively as Dr..

energy spent on administrative or technocratic pressures. On January 20th I witnessed a visit from the clinical administrative manager (who was once team lead and member of the team). The two service providers in the great room were very comfortable and open with him but he spoke directly with the current team lead in private. Although he is the manager, he is not involved with the daily decisions of the team and does not attend team meetings. As a team they have autonomy. Because he is not at all present I decided it was not necessary to interview him or include him in this project (in the 7 months that I was there I only saw him once). The team lead's role is much more present and very involved with work organisation. She explains it as follows:

> *Alors c'est moi qui s'occupe de l'organisation du travail et des relations de travail aussi parce qu'on est une équipe qui travaille dans un même quartier, ensemble en fait, ce qui fait que la cohésion de l'équipe est super importante pour moi. J'essaie de regarder aussi, pour qu'on travaille avec des outils, qu'on utilise le plus d'outils possible pour faciliter notre travail au près de la clientèle. J'essaye d'avoir un regard là-dessus. La structure aussi, un agent facilitateur je pense. [Les outils incluent] le plan d'intervention par exemple, les notes aux dossiers, des évaluations peut-être un petit peu plus spécifiques en toxico. Comme chef d'équipe, c'est de regarder les forces des gens et là où ils sont bons. Pour moi, c'est important que les gens soient biens ici.*

She is the 'buffer' between management and the clinical team, and between the institutional and the community. Thus we might think that this type of structure also allows for professionals to be more creative, autonomous and flexible (Khoury and Rodriguez, 2015).

Psychosocial and nursing service providers

I observe that the nurses are often physically 'separate' in their nursing or medical room[76]. In addition, two of the nurses demarcate their professional roles more rigidly; since the nurses remain at the clinic on a weekly rotation, they naturally engage in less community

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[76] Metabolic follow ups and medication injections are administered in this room by the 3 person nursing team

work and more injections/nursing in the nursing room. One nurse, who recently joined the team from a first line mental health team, offered to more regularly engage in non-medical activities such as home visits and community accompaniment. During the interview one of the nurses expressed her perception of the centrality of the nursing role because of the ability for nurses to do everything, including handle medication, whereas, she states, social workers cannot explain secondary effects of medication to a service user or the effects of medication during psychosis. An extract from that interview includes the following statement:

> *Donc c'est ça, justement dans une équipe SI [ACT], l'infirmière quand même est une personne ressource importante parce que sans elle, tout ce qui a à faire avec la médication, l'évolution du patient sur le plan mental et tout ça, on a besoin quand même d'une infirmière. Par exemple, on est très polyvalent, on fait de l'accompagnement, on fait des achats, on fait des demandes d'hébergement, alors que ce n'est pas notre rôle réellement (Allison)*

In contrast, these next statements from two of the social workers summarizes the perspective from most of the non-medical service providers, which is focused on accompaniment and which places a strong value on that accompaniment:

> *des fois même je te dirais, [les clients] vont nous confondre. Ils pensent qu'on est des infirmiers. Souvent, on me demande si je suis infirmière… alors que mon rôle ce n'est pas d'amener un diagnostic ou qu'au moment qu'ils me parlent des symptômes, ce n'est pas à moi de juger (Christine)*

> *On est intervenants, comme tous les autres dans l'équipe, mais on est plus responsables de faire certaines évaluations. C'est toujours difficile de différencier parce qu'on est vraiment…on est amené à faire un petit peu de tout, en fait chacun. Mais notre rôle vraiment spécifique de TS ça va être plus dans les évaluations de protection, les évaluations psycho sociale qui a à faire. C'est ce qui va nous distinguer des autres de l'équipe mais on est tous amené à faire des suivis psycho social et des accompagnements et d'être là pour les gens dans leur cheminement. (Sue)*

One service user specifically pointed to the role of social workers in helping with daily living:

> *Oui, c'est ça travailleur social. Les médecins c'est pour la médication, médicaments. Travailleur social c'est pour…travailleur social ça touche à*

> *tout. Si tu as besoin de quelque chose, tu demandes au travailleur social et il va te trouver des solutions. Des fois ils te proposent des choses aussi.(Estelle)*

This service user is referring to the ongoing dichotomy, although less severe than in the past, between the medical and the social in psychiatric care. She continues to express her satisfaction with being able to go to the ACT office four times a week stating that althought there is no specific objective to the meeting or intervention, she appreciates the ability to go out and chat:

> *J'aime ça venir ici, ça me fait sortir… On jase. On ne travaille pas vraiment quelque chose. On va prendre un café, on jase. Je leur parle de ce qu'il se passe dans ma vie.*

Another service user *Chris* is happy to meet with his service provider at home or in the community:

> *[on prends] un café et tout ça. Le Suivi intensif vient à tous les jours sauf les fins de semaine. S'ils voient que tu ne* feel *pas bien, ils viennent le samedi aussi. Ils connaissent mon dossier, c'est comme d'égal à égal. Le rapport client n'est pas là. Ils nous rejoignent à notre niveau. De tout. Ça parle des problèmes personnels, des problèmes politiques, tout ce qui entoure la vie d'une personne.*

Engaged and active psychiatrists

The psychiatrists are vocally and actively interested in developing a non-medically focused practice through tight collaborations with non-medical professionals. They seem to be influenced by what is happening in their territory and the lived realities of the service users. They are also acutely aware of their power and influence and are trying to use it in a political manner. The relative engagement and the progressive vision of the psychiatrists are central to the specificity of this team as both a clinical and political space. In what concrete ways are the psychiatrists engaged and politically active? Their clinical posture of team membership rather than authority over the team has the effect of promoting autonomy and non-medicalized interventions within the team. One psychiatrist, *Ruby,* went to the National Assembly to discuss needs of homeless population and *John* has been in the media regarding the PRISM[77] project. The ACT team feels the strain of decreased staff, which is intensified as pressure mounts to accept more and more service users. During the week of January 14th, 2014 they are particularly concerned with their caseloads and the referrals of 6 new service users with the introduction of 2 new staff members (*Karl* and *Andrew*). *Allison* is part time nurse at the PRISM program and therefore works at the nearby homeless shelter, Old Brewery Mission (OBM), on Monday, Wednesday and Friday afternoons. During an informal conversation about this the psychiatrist explained that it is necessary for them to remain relevant to the parent institution in order to be able to lobby for funding to grow as a service and develop innovative practices and services specifically to respond to the needs of the homeless population.

PRISM is a pilot project that was initiated by the psychiatrists at this ACT program. It is the result of their engagement and lobbying for street psychiatry services and an organizational framework that would support community outreach intervention. In a presentation given to students at Université de Montréal's School of Social Work in the course *Santé mentale: aspects socio-politiques*, the PRISM project is described as having:

> …an approach adapted to the individual wherein recovery is not seen as opposed to the coercive legal tools that are available. The PRISM program is part of an alliance between the institution, ACT, and the community, Old Brewery Mission (homeless shelter), focused on street psychiatry, outreach and stabilizing the individual in his or her milieu of choice. (Girard, 2015, author's translation).

The team lead explains to me that more and more new service users are homeless or have experienced homelessness. Another service provider offers a more colourful explanation

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[77] Projet de reaffiliation en itinérance et santé mentale

for the need for a program like PRISM stating that many service users are "in bad shape" (*magané à la grande échelle*, *John*). This profile, officially understood as clientele with multiple and complex needs, means that the service providers' time is required in a way that is not necessarily calculated or sanctioned under current organizational frameworks. The concept and approach of PRISM is strongly shaped by their commitment to respond to the needs of the homeless clientele in their territory and exposes their explicit perspective of mental health recovery.[78] Both psychiatrists received training in 'street psychiatry' in the U.S.A. and are actively pursuing practice approaches that involve meeting service users, particularly people who are homeless, on the street, at community organizations, or for a coffee in the community. Moreover, they have created a space of discussion and meetings for policy actions to be carried out which would in turn change the organizational structure of their team.

However, this macro and meso-level activism is not necessarily felt directly by service users at the micro-level of interactions and interventions. *Estelle,* like *Liz* who is quoted above, described the psychiatrist's role as focused on medication prescription:

> *En général, je lui demande de changer mes médicaments et ça fini là. Ce n'est pas comme un psychologue qui va chercher, qui va me poser des questions, qui va me demander à quoi je rêve la nuit, fait moi un dessin, qui va m'expliquer ce que ça veut dire le dessin. C'est juste pour me prescrire des médicaments pour que je n'aie pas le gout de consommer et que je me sente bien.*

Nevertheless, at the micro-level, some service users, such as *Joel*, would never have encountered the ACT team had the PRISM program not been established through the engagement and activism of the psychiatrists. PRISM quickly referred *Joel* to ACT and with their help found a room to rent; for the first time since the age of 17 *Joel* is not living in

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[78] As such, as of the winter 2015 the ACT team was working towards the development of a specialized Homeless ACT team, focused on community outreach interventions and housing within a framework that gives service providers even more flexibility. In 2016/2017 this team became a reality.

homeless shelters. Within a few weeks he established himself in his apartment, even finding a rat, which he kept as a pet in a hamster cage that his service provider procured for him.

It is thus important to remember that what happens within the ACT team between actors is also influenced by, and has an influence on, what is happening in society – at the local and political level. The fact that the psychiatrists are engaged with political actors is not necessarily an aspect of ACT that is outlined in fidelity scales, but is coherent with both the impetus of developing community-focused practices and the necessity to take into consideration social determinants of health and work to improve these conditions at the social and institutional levels.

These actions are strongly supported by the team especially the team lead. She explains to me that they are working toward renewing practice in community psychiatry and are lobbying the government for more appropriate care to respond to the realities of urban clientele (homelessness, co-morbidity). The psychiatrist, *John*, was the driving force behind the development of PRISM in partnership with the downtown not for profit working with homeless men and women, Old Brewery Mission (OBM). The changes to the system require internal activism – the government will not continue to fund the team if they don't maintain their caseloads and if they don't respond to the fidelity scales as articulated in the literature. However, the psychiatrist explains that the team cannot follow the American ACT model too closely for several reasons (one of them being that the service providers in Québec have collective agreements that cap their work week at 35 hours). The other psychiatrist, *Ruby* is also engaged, although she has not penetrated the political sphere as much as her colleague. In April 2014 she attended the Québec government's general assembly on homelessness in order to be at the forefront of a new proposition to have a rotating shift for psychiatric emergency rooms. The team lead, *Christine* is also implicated in a pilot project to have a social worker present at the psychiatric emergency room in order to respond to psychosocial issues before resorting to medication or medical interventions.

Shared caseload

> *C'est une clientèle quand même qui a beaucoup de besoin, c'est quand même l'intensité, il faut évaluer l'intensité des besoins. Souvent, je me dis, si j'étais seule pour répondre aux besoins d'une seule personne, je ne pourrais pas alors à la gang…J'ai une devise : toute seule je vais aller vite, ensemble on va aller plus loin. Alors c'est ça l'apport qu'on a. La beauté d'une équipe SI [ACT] c'est qu'on travaille tous ensemble dans une même direction. (Christine)*

Much of the professional knowledge transfer is also informal and part of the 'water cooler' talk. I observed many different 'talk spaces'; that is to say, service providers interact and share knowledge with each other spontaneously at their cubicles, standing in doorways, standing in the photocopy room, or even in public spaces such as the elevator or on the street. Public conversations were always coded and brief and did not occur if people outside of the ACT team were present. The interviews and my informal conversations with service providers demonstrate that they are trying to have less informal conversations with each other and to be more consistent in terms of writing notes in the files. The reason being that sometimes a worker makes a decision regarding a service user and doesn't write it down anywhere. Then if that person goes on vacation there is a risk that the decision is inadvertently reversed to the detriment of the service user. For example, on March 11 *Liz,* a service user, was still waiting to be evaluated and accepted for supervised residential housing at one of Montreal's mental health institutes. The team says her principal service provider, *Allison*, might know where she is at in the process but that nurse is on vacation and there are no notes in the file. In addition, my field notes from the March 25, 2014, 11am meeting also highlighted some communication concerns within the team (who does what, for whom, when?). One of the service providers commented that sometimes decisions such as cancelling a meeting are made during the course of the day by secondary service providers or the shift manager but the principal service provider is not always aware as to why. Thus, although I observe very little technocratic influence or pressure regarding statistics keeping, note writing or keeping a specific schedule, tension in staff relationship sometimes results. Nevertheless, I am struck by how each staff member remembers all the little things to do for each service user without necessarily writing notes. These things might include helping them check their mail or giving them a piece of mail that arrived at the office, discussing and establishing budgets and money or remembering that they requested an extra $20; making specific calls for housing issues such as changing apartments, talking to a superintendent or landlord. This is all possible because of very little discussion around administrative procedures or pressure to keep statistics.

The use of a specialized case management model, that is, one in which there is a sharing of the caseload, is discussed by some participants as limiting the ability to develop deeper relationships with service users:

> *Une des limites c'est évidemment le fait qu'on est plusieurs intervenants, que peut-être pour certains, c'est plus difficile de maintenir un lien de confiance avec différentes personnes. Aussi, au niveau du travail psycho social, c'est plus difficile pour les intervenants de maintenir un suivi si on veut un petit peu plus psychologique ou un peu plus sur le vécu qui aurait pu être traumatisant pour des personnes. C'est difficile à ce moment là, quand l'information est partagée, quand ce n'est pas toujours la même personne qui se présente, d'aller plus en profondeur dans ce genre de situation là. (Angus, service provider)*

In a similar vein, one of the service users, *Terry*, stated that one of the limits of the program for him was a lack of time to delve into important topics with the service providers ("*on* *manque du temps*”). *Terry* discussed his desire to develop a relationship with the service providers, but he often saw 2-3 different service providers and is left with the feeling that he is unable to fully tell his story. Other service users such as *Chris* explained that he felt the ACT team was a great team (“*une belle équipe*”) but that because of the frequent contact with many different service providers he had not developed a particular relationship with one person.

5.2.4 Flexibility and intensity – inherent in the structure or dependant on the actors?

Other major differentiating factors of the ACT team compared to other specialized mental health care teams are the flexibility and intensity that are hallmarks of the ACT fidelity scales. What do these descriptors look like in real life? In interviews service providers say that flexibility and intensity are what differentiate ACT from other community mental heath services. While walking and talking with *Derek* on a busy downtown street on the way to visit a service user, he tells me:

> *“En tant qu’intervenants, nous avons beaucoup d’autonomie et liberté et flexibilité”.*

The ACT program’s continuity of service through its connection to a parent institution is a key factor ensuring flexibility and clinical autonomy, as per one of the psychiatrists who explains:

> *C’est clair je pense de plus en plus dans la littérature que [ACT] est un plateau technique flexible, adaptable. Ce qui est pour moi de loin supérieur dans le modèle qu’on a ici par exemple par rapport à New York, c’est que le Suivi intensif est rattaché à un établissement et donc on est capable de faire la continuité. Le patient peut être vu à l’urgence, on peut nous l’admettre d’ici à l’urgence. On a des privilèges d’admissions directes, on n’a pas besoin de négocier avec personnes (John)*

This vision of flexibility, that is, to be able to impose medical and traditional interventions on service users is contested by the recovery and by progressive mental health literature. *John* anticipates this perspective and continues by stating:

> *Maintenant, des gens diraient : « À ce moment-là, c'est trop institutionnel et trop médical et on utilise trop les recours hospitaliers comme par exemple l'ordonnance de traitement ». Donc, certains pourraient critiquer ça, moi pas du tout… Je pense que d'avoir tout sous la main, c'est ce qui nous permet pour des clientèles d'une maladie, d'une sévérité inouïe, d'avoir la possibilité qu'ils soient en logement stable pendant deux ans et plus et de les sortir de ce parcours-là, on a besoin de tout ça.*

The organizational structure described above provides a good foundation for service providers to be flexible with their timing and schedule and for all service providers to taint the overarching team perspective on care. That means that when they visit a service user for a coffee, to deliver or administer medication, or for a visit, they can take as long as the service user needs. Sometimes this is 5 minutes, and sometimes a simple *Med drop* becomes a 30 minute intervention.

Another service provider explains that the particularities of ACT come from their flexibility to be in the community and thus to interact with service users in a way they could not in other psychiatric teams. His statements also evoke the specific privileges and power inherent in the invasiveness of the ACT team and also the potential to build relationships based on participation, empowerment and the expertise of the service user. The intimacy that the intensity and the intrusiveness of ACT programs requires can be potentialized to gain in-depth knowledge and trust with a service user:

> *Suivi Intensif, c'est vraiment à l'extérieur, c'est une approche vraiment égalitaire avec le client. On a accès à des choses plus intéressantes à l'extérieur et chez lui aussi. C'est ça la différence, ce n'est pas du bureau. Tu n'es pas dans un bureau avec le client, c'est tout l'aspect d'être vraiment à l'extérieur avec le client.* **…** *Être chez un client, on voit son intérieur, son intimité. Le milieu de vie en dit très très long sur le client. Donc ça peut être très parlant au niveau de son*

> *environnement. Ça c'est intéressant. On a accès à des choses qu'on ne voit pas dans un bureau. (Dean)*

However, there are constraints. Several times at 11am logistical meetings the team raised concerns about service users not letting them into their apartments. This might be an indication of trust issues, privacy issues, and the paradox of an intense service. During the interviews, most service users agreed to explain to me how they understood the ACT program and its role in their lives. Many stated that when first approached by the team lead (usually during a hospitalization) they were not sure what to expect. Most of them understood the ACT team as a service that helps them with their daily lives. Some of them accept that as a fair trade for the intrusiveness of medication visits:

> *Au début, je n'aimais pas trop [les visites pour la médication] mais après ça c'était correct. (Charles)*

Other service users such as *Estelle* succeeded in arranging her interactions with ACT in a different way:

> *Et là je viens ici et j'aime mieux ça de même parce qu'eux autres ils viennent entre telle heure et telle heure, il faut que tu sois chez vous. J'aime mieux venir ici comme ça je peux gérer mon temps.*

The team is aware and discussed these concerns: it seems that many service users are upset that the ACT team comes for *Med drop* at different times so they are not able to plan their days accordingly. This caused a somewhat defensive reaction in one service provider who stated that the service users should not complain about having to wait an hour or so for a visit. However, the team lead once again set the tone and disagreed vehemently with this perspective stating that it would be 'unacceptable' to make service users wait for the ACT service as if they were a telephone service (“*inacceptable de les faire attendre. Nous ne sommes pas Videéotron ou Bell”, Christine)*. In the end, the morning and evening *Med drop* routes were modified in order to ensure that service providers arrive at service users’ homes closer to the predefined time.

Flexibility exists in the sense of professional autonomy but not necessarily in the sense of choice of approaches (there is an almost exclusive focus on psychoeducation, individualised interventions). As *Derek* tells me while walking on the street:

> *L’équipe voulait développer un groupe, comme un group d’activité pour réunir les personnes, mais le Centre d’excellence est venu nous évaluer et ils on dit que notre mandant n’est pas de créer des groupes au sein du programmes mais plutôt de référer les gens aux groups communautaires*

These constraints come from the CNESM that evaluates the ACT program according to its fidelity to the TMACT scale. One of the nurses, *Andrew*, says it is sometimes frustrating not to have more time with service users and that despite the notion of flexibility, the reality is that there is pressure to see many service users for many *Med drops* every morning and evening. This nurse previously worked in primary care mental health and has experienced working in a case management modality. He observes that often in ACT there is not actually enough time and space to explore with service users their true needs, desires, and dreams *(“il n’y a pas actuellement assez de temps ou l’espace pour explorer leur besoins, desires et reves”*).

In addition, there are clear, yet intangible frontiers laid out by the actors on the team, most notably the service providers. For example, *Karl* was the main service provider for *Chris*. His dream as per his IIP was to see a live soccer game. So, with permission from the team, *Karl* spent a Sunday afternoon in *Chris’s* company watching a Montréal professional soccer team play a game. The ACT program paid for the tickets, and for *Karl*'s time, as a way of fulfilling *Dean's* dream, and thus, in their perspective, supporting his recovery. However, these flexible, creative, and perhaps friendlier interactions are only sanctioned under the condition that it is done within 'working' hours. For example, one service provider, formerly with the ACT team but now transferred full time to the PRISM project had a day off. On this day he decided he wanted to visit a service user with whom he had a special bond and who was no longer followed by PRISM. This action was mocked and even degraded by the team who thought it was an indication of the service provider being unable to maintain his professional boundaries.

The following two examples illustrate the impact of individual, subjective judgement on what is acceptable. In other words, the meaning prescribed to the behaviour and actions of service users presupposes the interactions and construction of interventions with a service provider. The first example comes from a service user who observes the intangible, but ever present frontiers to the level of flexibility and intensity the professionals can provide:

> *Moi je trouve qu'une rencontre par deux semaines ce n'est pas assez. Ce que j'ai eu de la difficulté au début, quand tu as une relation, un proche intime avec les intervenants, il se développe une forme d'amitié. Au début, je les accompagnais jusqu'à l'ascenseur. Tu as remarqué, là je vous laisse et moi je reste dans mon appartement. Ils m'ont fait comprendre subtilement que ça ne se faisait pas pour eux. « Mr Duguay, quand vous allez à l'ascenseur avec nous, posez-vous la question, est-ce que c'est de la dépendance ou est-ce que ça fait partie de vos valeurs »? Moi je pense qu'ils ont jugé que c'était de la dépendance alors que ça faisait partie de mes valeurs. Ils sont venus chez moi, ils se sont déplacés, je les accompagne jusque là. ... La deuxième chose que j'aime faire, c'est donner des câlins aux gens que j'aime. Ça ne se fait pas pour eux-autres. C'est passer une frontière, une balise offensant pour eux. Alors je ne donne plus de* hugs*, de câlins parce que ça ne se fait pas pour eux-autres. Ça, ça m'affecte, tout mon être. Mais là, je me suis habitué à cette façon de faire là et je vais mieux là-dessus. Il manque de chaleur humaine à quelque part, ils sont très chaleureux, très empathiques et après ils veulent un mur. (Terry)*

The second example takes place at a team meeting. *Angus,* a service provider, is concerned for *Olivier*, a service user. He is worried that *Olivier* is decompensating because at the morning *Med drop* he was wearing black eyeliner. For *Angus*, the moral assumption was that the use of makeup in a man who has not previously been seen wearing makeup is not an acceptable behaviour. His concerns were dampened by his colleagues *Christine* and *Karl* who insisted that the use of black eyeliner is not an indication of deviance and that their role is not to regulate an individual's makeup or clothing.

The contrast between these examples illustrates that flexibility is in fact introduced by individuals and their underlying values and motivations, and not necessarily by the organizational structure itself. In short, the *ethos* of the team and of individual service providers indicates that the norms and standards for desirable ways of acting and interacting were not being met by *Terry* or *Olivier.* The *ethos* of this team, that is, the way they believe that service users should behave, develop, and feel (Geertz, 1973) influences the meaning prescribed to interactions and influences the flexibility that is promulgated regarding both relationship-building within the organizational framework.

Although it may be a service modality with a lot of flexibility and a maximum of resources ("*une modalité extraordinaire avec beaucoup de flexibilité, beaucoup de ressources aussi, un maximum de ressources"*, *John)* there are still important constraints placed on the ACT team by the parent institution, the *Centre national d'excellence en santé mentale*, and the Ministry of Health and Social Services. The personal influence that individuals have on how flexibility is defined should not be underestimated. Regardless of that, there is an important, inescapable rigidity in the tools that are available to the team. These are mostly related to the way medication and a reductionist biomedical perspective continue to have a structuring role. These rigid tools sometimes make it easy for service providers to set limits, or engage in coercive practices. This will be discussed in detail in the following section.

5.3 The structuring role of medication

The dominant vision in psychiatry is one in which medication is structuring and preserves a certain social order; service providers maintain control and power over service users, often through the use of pharmacological interventions to the exclusion of other psychosocial, psychological, social, or political interventions. As we have seen in the previous section, the activism and engagement of the team, particularly the psychiatrists, has created a sort of hybrid team that is frequently juggling a somewhat progressive, service user-oriented, community-focused approach within the governing, often reductionist, biomedical perspective.

One of the psychiatrists explained the particularities of this ACT team as follows:

> *24/7, mobilisation communautaire, équipe pluridisciplinaire. C'est ça qui fait que nous sommes fidèles au modèle ACT. Administrativement. Maintenant la participation des usagers et mobilisation communautaire dans la quotidien et plus une question des valeurs" (John)*

In the next chapter we will explore how some of these values are played out through the actions and interactions of actors within the ACT team. However, in order to contextualise these, understand the actors' relationship with madness, and to continue with the thick description, I will first underscore the ways in which medication, and medical interventions are a structuring force. For example, one service user explained to me his difficulties and why he is taking medication:

> *…de minuit à 6h00, j'ai de la difficulté…je me sentais inconfortable. Une douleur morale comme disait le [docteur]. Il m'a prescrit au besoin une médication et ça fonctionne bien. (Chris)*

Medication is the first recourse of action for a variety of difficulties, moral, physical, spiritual, and psychological. The reason might be the lack of tools and approaches outside of pharmacological or behavioural interventions that are available to the team. Medication is also a fundamental and central aspect of the ACT program, according to the literature, the interviews, and my observations. Surprisingly, it is an aspect of the job denounced by all of the psychosocial staff. Each expressed the sentiment that they have had to learn to live with that part of the job.

> *C'est une place que je déteste, je le répète encore, je la déteste. Je déteste faire cet aspect de ma job : ramener la médication, superviser la médication, attendre que la personne ait pris ses comprimés, moi je dois valider ça. Je trouve ça un peu…ce n'est pas tout à fait mon truc à moi, mais bon, ça fait partie de mon job, il faut le faire. (Dean)*

However, the team structure, specificity, and values are nevertheless trying to carve out room for creativity and practicing in a way that is different from typical institutional arrangements.

In the above section I touched upon the ways in which flexibility is experienced in this team, and the concern from some participants that the team is 'flexible, but'. There is rigidity in the tools that they use or have at their disposal such as treatment orders and other laws such as the P-38, not to mention enforcing conditions places on service user by the *Tribunal Administratif du Québec (TAQ)*. Some participants state that implementing these tools are the easy options for intervening, as they require service users to submit and remain subjugated to the authority of the service providers. *Liz,* a service user, recognizes the way medication and socio-legal tools are easily deployed by psychiatric services:

> *Ce n'est pas une job vraiment difficile...Qu'ils puissent me renvoyer à l'hôpital n'importe quand. Ils peuvent faire ce qu'ils veulent.(Liz)*

To begin, an understanding of the most implemented legal tool, the P-38 must be defined and understood from the perspective of participants.

5.3.1 The space occupied by legal tools

Service providers are constantly using interactions with service users as a way to assess service user risk to themselves or to others. This is done in the 11am meetings and in informal conversations. Assessing risk and managing that risk is a major part of psychiatric ACT interventions, regardless of profession. However, the perception of risk, especially as it is constructed with in the *ethos* of the service provider, remains a subjective one in which, as this service provider explains, there is not always consensus:

> *On ne s'entend pas tout le temps, tout le monde. Des fois le médecin aussi va prendre une décision qu'on n'est pas tout à fait d'accord.... souvent la gestion du risque. C'est souvent ça où on ne s'entend pas sur le traitement.*

In the Chapter 7 I will explore how service providers quantify their subjective assessment of risk during interactions with service users. For now, I will present the tools that are frequently used when a) the team feels that they are unable to obtain the cooperation and consent of the service user and b) the level of risk of harm for the service user or others is evaluated as being high. The medical legal tools most frequently employed by this specialized team are legal treatment orders (*Autorisation judiciaire des soins)* and the Law P-38 that results in forced confinement.

Québec's law P-38 was created to prevent long-term involuntary hospitalizations. It is known as the *Loi pour la protection des personnes dont l'état mental présente un danger pour elle mêmes ou pour autrui,* Law for the protection of people whose mental state presents a danger to themselves or others. Essentially it removes a person's liberty, due to their mental state, by confining them, usually in a hospital setting. As such, it is considered to be a 'law of exception' that is to be used in exceptional circumstances when no other recourse is possible. Although its application forces an individual into care, it does not give the right to treat someone against their will - a legal treatment order is required in order to do that. Confinement requires a psychiatric evaluation that concludes that the individual presents a danger to herself or to others, but the confinement itself is imposed by a judge from the Courts (*La cour du Québec)*. Because this can be a long process, the law allowed for two other mechanisms to expedite the process. The first is preventive confinement (72 hours) that does not require authorization from the *Cour du Québec* and can be done prior to psychiatric examination. A police officer or crisis worker usually applies this preventative confinement order when the danger that the person presents to himself or others is judged to be serious and immediate. The second mechanism is known as provisory confinement and is applied most usually by a third party, such as a service provider or even a family member, when the person's risk is assessed as severe but not immediate. This provisory confinement refers to the period where the person is confined in order to proceed with two psychiatric evaluations in order to eventually have a regular, or authorized, confinement (Veilleux, 2015); it is sometimes also referred to as 'psychiatric referral'. The challenge is to ensure that P-38 remains an exceptional law and isn't applied to every situation in which service providers feel that they are at an impasse. According to the mental health activist group, *Action Autonomie*, the usage of P-38 in Québec is on the rise with 2460 requests submitted to the courts in 2008.

Treatment orders (for pharmacological treatment or for residential care) are legal documents allowing the treatment team to administer pharmacological treatments against the service user's will. The request for these must come from a psychiatrist and authorized by a judge (*La cour supérieure).* The psychiatrist must deem the service user inapt to consent to their treatment as a reason for invoking a legal treatment order. On an almost daily basis during my field work, treatment orders were discussed as a possibility to either request one for a service user who is noncompliant with medication or in terms of applying a treatment order for a service user who already has one but remains noncompliant.

The use of these medical legal tools in practice meant that risk is often managed through medication or hospitalization. Not only is there control over service user actions and interactions with the team and with the community through medication due to the use of this tools, but the team's vision of risk management is often reduced to a hospital-centric one in which non-compliance and sometimes even attempts at agency are met with forced medication or hospitalization. Sometimes, however, these tools are used in a way that allows service proviers to intervene at the site of protecting service users. For example, during the field observation period, one of the service providers was in what he referred to as a "delicate situation". A service user, *Martin*, was living in community-based supervised housing. The intervention team at this housing unit discovered a list of firearms that *Martin* wanted to buy. They were alarmed and immediately asked the ACT team for a psychiatric evaluation leading to a court order for hospitalization (P-38, provisory confinement). Although the team was aware that *Martin* had already purchased a bb gun, in order to protect *Martin* so that he does not experience prejudice and possible eviction they chose to keep this information confidential and not inform the housing unit. Instead, in parallel to the provisory confinement, the team psychiatrist requested a legal treatment order to ensure medication compliance through injectable psychotropic drugs, which was accepted. The team was satisfied with this and did not feel that the housing unit required more information as they have established control through medication. The service provider explains that they managed risk as a team, they did their job ("*On a géré le risqué en tant qu'équipe, on a fait notre job*", *Derek*).

In many ways this is an 'elite' team of mental health professionals who have experience, knowledge, and a significant amount of power as they enter into people's homes and communities armed with the possibility of applying the P-38 law of exception and legal treatment orders as well as the fact that they are 'end of the line' of external care psychiatric services. However, this elite team also expressed feelings of powerlessness at being the 'end of the line of care'. This perceived pressure sometimes leads service providers, especially those with less field experience, to react more aggressively to certain situations with service users. For example, a more recent addition to the ACT team, a service provider with less than 6 months of direct practice experience, expressed his opinion regarding the possibility to co-define interventions with service users. Speaking about the majority of service users, or the typical service user, in an ACT program he says:

> *C'est une dernière ligne de service pour ces gens là, la plupart du temps, ils sont maganés et pockés. Je pense qu'une fois qu'ils sont remis sur pieds, là oui ils ont le gout…mais le rapport qu'on voit ici présentement, ils ne sont pas très positifs envers le service. C'est très difficile de les accrocher, on représente l'autorité qui rappelle la maladie. Si on veut aider la personne, peut importe la manière que ça soit fait, si c'est adéquat et justifié, je vais être d'accord. Ça prend des ordonnances de traitements, des ordonnances*

> *d'hébergement, on n'a pas le choix. Les gens qui sont suivis ici ce sont des gens qui sont très instables. Du jour au lendemain, on pensait qu'ils allaient prendre leur médication mais finalement, ils nous ont joué un tour, tu arrives chez eux, il est décompensé.*

One of the psychiatrists and the team lead explained that with the various socio-legal and medical legal tools they have a bargaining chip on their side: "*on un levier sur [les personnes utilisatrices*]" and it is necessary for them as professionals to have this because "with a legal treatment order we can do something with them" (*Ruby*). These statements bely the control and surveillance that service providers feel are necessary in order to accomplish their roles, manage risk, and interact with service users.

The authority inherent in the role of professionals and particularly in their role as professionals in an ACT team is not lost on the service users. One service user, *Liz*, explains the tensions that she experiences with the professionals who are at once personable and warm, but also hold immense power and control over the lives of service users. These comments from *Liz* illustrate her observations of deep seated tensions and contradictions within the ACT program about the way interventions are selected for different service users :

> *on ne sait pas s'ils nous veulent du bien ou s'ils veulent notre mort….[par exemple], moi je m'en vais chercher mettons quelque chose de le fun et lui il retourne à l'hôpital et je le croise. Eux, ils annoncent au gars, avec la police : Toi tu vas retourner à l'hôpital. Après deux minutes après, elle donne 40$ à une [autre] fille pour qu'elle aille acheter son épicerie. Ça ne fait pas de sens.*

As we can already see, the space and place used by the ACT team can have paradoxical impacts on the multiple actors. The occupation of these spaces at different times and in different circumstances give rise to tensions that are often invisible to the official structure of the program. The social roles that are played by the actors in an ACT team are varied and numerous, echoing the seminal discussions by Goffman (1959, 1961) that a group, or in this case a team, plays a central role in the actions and interactions of individuals within that team. Once they know the established roles and rules of play can ‘improvise’ individual actions that are be chosen based on the effect that they might have on others.

We will now turn to an examination of the meaning of recovery and recovery-oriented practice (Chapter 6) and specific actions and interactions that are the result of, and that continuously influence, these structures (Chapter 7).

Chapter 6: Making sense of recovery

Now that I have discussed in detail the space and place of the urban Montreal ACT program, the structures that define and influence it, and the roles and relationships that are acted out within these structures, it is time to turn to the question of mental health recovery and recovery-oriented practice. I will now address recovery directly by examining *who* is talking about recovery and analyse *how* recovery plays out in these structures. In the following chapter, I will analyze *which* interactional situations amongst participants are tied to recovery-oriented practice indicators namely - flexibility, community mobilization and engagement, recognition, participation, and acting upon social inequalities – and I will analyze *how* and *why* these actions and interactions were observed

The perspective of recovery and the roles and relationships that are produced in the ACT team are of course influenced by each individual's personal experiences and worldviews. It is with a respect for this plurality of understandings of mental health recovery and recovery-oriented practice that this chapter will sharpen our understanding of the intersubjective nature of these processes. Before providing an analysis of the way in which recovery is discussed and acted upon, I will present interesting findings that help us to understand the way in which action and interactions, and relationships, within the ACT team are framed by service providers.

6.1 The use and avoidance of diagnostic language

Service users are informed of the ACT mandate at the initial triage interview. They are told that a referral was made on their behalf so that they could have a follow up with a team that would help them to avoid hospitalization, live in the community, and maintain mental health stability. Of the service users I interviewed, many of them expressed a positive experience with the interactions they had with the ACT service providers and with the interventions they received:

> *Ça va de mieux en mieux, il y a plus d'encadrement. Et c'est ça, ma santé mentale va mieux…Je pense que oui ça va mieux. Je suis plus responsable par rapport à mes amitiés et mes relations (Nathan)*
>
> *Ils ne font pas juste me renvoyé à l'hôpital. Quand je suis rendue vraiment* kaput*, intoxiquée, ils ne m'envoient pas à l'hôpital. Ils ont accepté que je sois un bon bout dans la rue et c'est une expérience que je voulais vivre et je suis contente qu'ils aient accepté ça. (Liz)*
>
> *Ma relation avec les autres est meilleure. Ma relation aussi avec moi-même est meilleure. Ils m'ont amené à réfléchir à des situations ou des états d'être que je ne savais pas que j'avais en dedans de moi. Ils ont été et ils sont encore très précieux pour moi. (Terry)*

It seems that service users are prepared early on to anticipate those services and evaluate their experiences based on those expectations. Nonetheless, further exploration of their experiences, woven throughout this chapter and the next, illustrates a more nuanced perception of their life within an ACT team.

Supported by the fidelity scales and ACT literature, and by an overall focus on medication and compliance, most interventions are focused on maintaining housing, medication compliance, hygiene, some community contact, and perhaps employment of training programs. One of the perverse effects of this focus, coupled with the intensity of the contact between service providers and service users is, as one service provider stated, losing touch with the person in question: "*parfois on s'occupe de leurs biens, mais on oublie facilement la personne*". This sentiment was shared with some of the service users, one of whom explained:

> *ça me déprime que je ne puisse pas avoir les outils pour non seulement, pas juste avoir un appartement mais aussi construire ma vie mais eux ils ne peuvent pas m'aider parce qu'eux c'est juste l'appartement, la bouffe. Mettons la bouffe, l'appartement, le chauffage, la télévision. Mais je n'ai pas d'outils pour ma vie…On va manger, on prend un café. On fait pleins d'activités admettons, on va payer mes amendes, des affaires de même…Moi je pensais qu'ils allaient plus vouloir demander des informations à mes parents sur comment j'étais et vraiment comme, je suis plus un numéro, un dossier. C'est qu'est-ce que j'ai fait, ce n'est pas qu'est-ce que je suis. Mais c'est ça.* (*Liz*)

The above citation represents a continued reliance on diagnostic tools and language, mostly in order to ensure that behaviours and pharmacological treatment are adequate. Paradoxically, the ACT service providers denounce coercive practices that focus on medication adherence. The team philosophy also shies away from formal diagnostic language, but replaces it with language to quantify subjective interactions in order to manage risk. This means that sometimes diagnosis, or even stereotyping, is used as a way to frame and name behaviours.

6.1.1 Quantifying the subjective

Psychometrics, the process of quantifying subjective outcomes, has traditionally been the purview of psychologists. Essentially the objective of psychometrics is to measure subjective outcomes such as quality of life, social health, pain, and patient satisfaction that are more precise than what is directly observable such as attitudes and aptitudes. These unobservable characteristics can also include the perception of risk associated with having a psychiatric diagnosis. Although the use of psychometrics is not an official or formal tool in community mental health services, the pervasiveness of the perceived necessity to quantify a service user's risk level is rampant in the discourse of service providers.

It is only through many months of observations that this invisible mechanism was observed. Service providers and even official documents discuss the necessity to manage or reduce risk. Yet at the same time there is an impetus to avoid the use of diagnostic language in an effort to welcome the subjective and qualitative aspects of a service user's psyche. For example, when the team lead introduces a newly evaluated and accepted service user, the diagnosis is not mentioned or questioned. Instead the team discusses the person's living conditions, family network, and history. However, the team will get around the use of diagnosis by using other terminology that attributes mental illness to behaviours. Adjectives and qualifiers such as "*il est propre", "il a un bon hygiène"*, "*il avait de la bouffe sur la table*" are ways in which aspects of the service user's life are presented to indicate to the team the level of the service user's well being. These qualifiers risk stigmatizing and stereotyping in that they serve to differentiate the service user from the service provider (Zarifian, 1999). Most often, on a daily basis in fact, service users will be described as 'adequate' ("*adéquate*") or 'collaborative' ("*collaborant*") meaning that they are not posing a risk to themselves or others; they are not bothering their neighbours and they are respecting their treatment indications. For example, in the Spring of 2014 when *Angus,* a service provider, visited *Nathan* for a follow up meeting*,* they did a load of laundry together. At the daily 11 am logistical meeting, *Angus's* clinical assessment of *Nathan's* current mental state and well being was succinctly summed up by describing him as "*super*". A colleague, *Sue* concurred stating that 'he's following the rules' ("*il suit*"). Later in that meeting, when *Karl* related his *Med drop* visit at *Melanie's* apartment that same morning he described her as 'sharp and adequate' ("*allumé, adéquate ce matin")*. In contrast, *Néomie* who was shift manager spoke with *Charles* that morning and described him as *"bizarre*". Eventually more diagnostic language does arise; for example, service users who don't like to leave the house are suspected of suffering from social phobia or service users who complain that too many different service providers come to their house, are sometimes dismissed as having a personality disorder.

The psychiatric diagnosis, applied by a psychiatrist, can be understood as a social practice in which the psychiatrist is in interaction with the service user. In a similar way, mental health professionals also use objective measurements to describe a subjective interaction with service users. This paradoxical quantification of symptoms relies on a service provider's subjective interpretation of an event or a situation that is then described and relayed as an objective truth. The subjectivity that exists in mental health practice and in the deeply social actions and interactions that guide this practice means that different service providers might offer different measurements of risk. For example, when a service user is described at an 11am meeting as more anxious, less depressed, or more nervous it is very difficult to discern if that is a reliable indication of the person's well-being.

However, the flexible and flat team hierarchy does create space for contesting a fixed reality and perception of service users. For example, *Karl,* service provider, described *Olivier,* service user, as 'slow and depressed' ("*lent et déprimé*") ever since the psychiatrist changed his medication to Haldol. However, *Néomie* retorted stating that she thinks 'he's doing super well' ("*il va super bien*"). The team lead then asked her to take some time to explain why she assesses him as "*super*". These unreliable measurements are not lost on some of the service users:

> *Je sens qu'il y a certains et certaines intervenants qui me jugent. Ça me fait quasiment de la peine parce qu'avant même que j'ouvre la bouche je suis jugé… Il y a certaines personnes du Suivi intensif quand ils rentrent chez moi, je suis heureux et il y en a d'autres que ça va être long. (Terry)*

One of the most significant barriers to wellness, recovery, or social inclusion, identified by service providers is stigma. One team member explained:

> *La société est une barrière déjà. Le jugement, l'étiquetage des personnes est une barrière énorme. Quand on juge les personnes, c'est une barrière énorme. On vit au Québec avec une société où il faut être compétitif. Les gens qui sont malades, c'est-à-dire le regard qu'on a sur des gens malades c'est un regard d'échec. Ça c'est une barrière. (John)*

The causes and consequences of stigma, in other words, the destigmatization efforts, are largely individualized and are left to the personal and professional approach of the service provider. For example, *Andrew* explained that he is particularly affected when he sees a service user being exploited or manipulated by members of society in order to benefit from the service user. *Karl* also discussed his destigmatization interventions. He explained that when he accompanies a service user in the community – be it during grocery shopping or to a restaurant, he takes off his work badge: *"Pour ne pas stigmatiser j'apparais comme un ami".* Certain service providers demonstrated a total lack of interest in social change or in social determinants of health by, for example, describing services users as, *"[des] gens [qui] profite de l'aide social, ça fait pas de sens*".

Despite the relative lack of use of DSM diagnostic language, the subjective measuring of adequacy or collaboration sometimes slips into stereotyping discourse. At a weekly team meeting two service users were presented. The psychiatrist responded to each presentation in turn with the following comments: "*il est encore parano. Ça fait 4 ans qu'il est à l'hôpital…il va être parano jusqu'à la fin de ces jours*" and "*il babotte comme un baleine presque noyer".*

The whole team laughed at these comments and images, which may betray a traditional and prejudiced psychiatric value system that is difficult to reconcile with progressive recovery orientations. However, it is plausible that these comments, and the reaction of the team are due to discomfort with difficult and complex situations and their particular situation as being the ‘end of the line’ service. Many professionals express feelings of helplessness or powerlessness related to this:

> *Comme je le dis des fois un peu cyniquement, c’est qu’on est un peu comme les parents de 85 ados. Ce sont des gens qui sont relativement immatures, qui ont de la difficulté à gérer leurs vies mais qui jonglent avec des problématiques très adultes, qui ont de la difficulté à comprendre je pense, qui ont de la difficulté à réaliser à quel point ces problématiques là ont des conséquences sur leur vie. Il peu y avoir des impacts importants parfois de leur comportement. (Derek)*

> *La personne qui est ici trois fois par semaine, elle nous voit cinq fois semaine pour sa médication, ça peut virer un peu anti-thérapeutique. Nous voir, ça lui rappelle qu’il est malade […] On est là pour les aider mais malheureusement, on leur rappelle des choses négatives.* (*Karl*)

This feeling of professional powerlessness and helplessness was especially true regarding the influx of new homeless clientele due to the partnership formed with PRISM and OBM. I observe a professional malaise with the new homeless clientele. The question they asked themselves was: “what do we do with this kind of suffering”. I was not sure if it is a feeling of powerlessness concerning ‘outcomes’ or if it is a feeling that the service user is powerless in making changes to his socio-economic situation. I discussed this at length with the team lead in the hospital shuttle bus one day and she explained that

> *Ce n’est pas une impuissance face à la clientèle itinérante mais plutôt un sentiment d’être tout seule sans ressource dans la communauté ou sans angle pour intervenir. Sentiment d’être tout seule devant le patient itinérant*

Even some service users express an internalization of this helplessness. *Liz* commented in her interview that she does not think the team will want to help her much longer because

> *Je n'ai pas assez d'amour ou d'appui. Je ne sais pas. C'est comme si demain…c'est comme si je ne pouvais rien faire parce que demain je vais peut-être mourir. Je ne peux rien prévoir parce que d'un jour à l'autre, les gens pensent : ça ne vaut pas la peine, elle va peut-être mourir demain.*

The complexity of service user mental health problems and the social inequalities that they face (such as poverty, isolation, exclusion, stigmatization) are often paralleled in their relationships within the ACT team. Again, the manifestation of this is very subjective and is often dependent on professional context. For example, when *Angus* explains that he evaluated a service user as doing well because he used the bathroom in his apartment and it was very clean, *Allison* responded by saying that she would rather urinate in her pants than at a patient's home (“*je préfère uriner dans mes culottes avant d'uriner chez un patient”).*

The cautionary tale presented here is one in which this quantification of a subjective experience and interaction might ignore the social and subjective sufferings so often associated with mental health difficulties; sufferings that extend beyond the framework of symptomology. Although the flexible and community-based structure of the ACT team does provide some opportunities for very specific micro-level destigmatization interventions:

> *Quand je sors avec des gens, normalement, je vais éviter de parler de la maladie ou de la médication. Ça je vais faire ça au bureau, ici. Sinon, j'ai des conversations normales avec eux sur tout et rien. (Karl)*

At the meso-level there are regular conversations with landlords and pharmacies to help create space for service users to meander a pathway, albeit a limited one, in society. I was told that there is work done with café and restaurant owners so that they may be more accepting of the service user in their shop. This meso-level work was briefly described in Chapter 4 and typically leads to destigmatization through an assurance that the ACT team protects the person. In short, the overarching imperative for harm reduction and risk management also guides the interactions with the community outside of the ACT team. As such, there is very little space, time, and flexibility for broader destigmatization efforts to be done at a meso or macro level.

In a way, these actions, interactions, and discourses mask the complexity of experiences that an individual might have and indicate that despite flexibility in service offer and a community-based location, the space to develop deeper communication is limited by the vestiges of a reductionist, traditional biomedical influence. This dynamic is evident to some service providers, such as the team lead who said that they are always assessing mental state and security but lamented this limited scope (“*besoin d’aller au dela de ces evaluations*”). When I discussed this observation with the team at a mid-point in the research process, most of them, including one of the psychiatrists, were completely unaware of these dynamics. These dynamics expose the assumptions about the service provider’s worldviews (Geertz, 1973). Their assumptions about what a service user is capable of and what motivates her are fundamental to the quantification of subjective interactions, to stereotyping, and to the type of destigmatization efforts that are employed. When I discussed this with them at the time, in an attempt to make conscious their mostly unconscious assumptions, they were open and willing to begin to make changes by describing the people they were visiting rather that offering a scale or measure of their subjective interpretation of the service users well-being. One service provider conceded stating ‘we should be intersubjective and objective’ (“*il faut etre intersubjectif et objectif”, John)*. Is this a contradiction or a plausible scenario within the ACT team structure and service offer? How can this be understood? Instead of understanding these contradictions and paradoxes as an example of the pervasiveness of hegemony or the omnipresence of objective, positivist evidence based medicine, I propose to think of this unstable balance between experience-based evidence and professionally imposed measurements as an essential part of the ACT team in the slow, progressive redefinition of mental health service providers' relationship with madness.

I can't help but think of this ACT culture as a juxtaposition of a collaborative intent and perspective within a traditionally hierarchical and coercive culture of care. On the one hand service providers and service users have room to manoeuvre in terms of time and space and more autonomy to potentially construct innovative practices with the service user. On the other hand there remain many barriers to this flexibility, most notably in terms of medico-legal and organizational constraints and influence. The rigidity of these constraints, such as treatment and housing orders, do create a certain *malaise* in both service providers and service users alike. Professional practice is moderated by this discomfort and uneasiness; service users experience a simultaneous relief at avoiding hospitalization coupled with a sense of surveillance and control in order to maintain their relationship with ACT. So how can recovery-oriented practice emerge in the face of these constraints?

6.2 What does recovery mean to you?

The team rarely directly discussed the concept of mental health recovery although, as mentioned before, discourses and actions related to recovery, or which could be understood within a recovery framework, were observed. In fact, the only time recovery was discussed directly by the team was when a peer support professional came to a team meeting with the expressed purpose of talking about recovery. Otherwise, recovery was a word used only during the research interviews, specifically when I asked about it. In the following section I will analyze the meaning and perspective of recovery, through the preconceptions held by each individual at the time of their interview and participation in this research. These individual preconceptions and predispositions to the word recovery, to the idea of mental health recovery, and to the actions inherent in recovery-oriented practice make up the intersubjective construction of the recovery-orientation in this ACT team. This analysis required exploring several concepts through which participants' meaning of recovery might be conveyed. Unpacking the notion of recovery required asking the questions: Is there a difference between a person who is on a recovery journey and a person who is not? What does it take to be in recovery? Recovery from what?

Through a dialogue with the discourses shared with me during the interviews, I propose to use the singular responses from participants to understand the intersubjective, collective construction of a recovery orientation within this team. The interviews took place starting in the 3rd month of observation (March 2014) and continued until the end of the observation period (June 2014). One final interview with a service provider took place in September 2014.

6.2.1 Service user discourses on recovery

Service users told me unequivocally that recovery was never discussed in a direct or formal manner with them, *« ils me l'ont jamais dit. Ils ne parlent pas de rétablissement »* (*Terry*). Again this is consistent with my observations that demonstrate that service providers do not mention recovery in their intervention planning. However, when I ask about it directly it is referred to as a relevant and contemporary issue.

The interviews with service users began with an open-ended question that asked them to talk about themselves and about what was important for them. Towards the end of the interview, after talking about the ACT program and the relationships they have with the service providers, I directly asked them about recovery. Each person had a unique, personal understanding of what it means to be in recovery, ranging from peace of mind and life balance, to avoiding episodes of psychosis and hospitalizations, to being able to respond to basic needs such as eating, taking medication, and socializing.

> *Le rétablissement…je suis en rétablissement depuis que je suis sortie de l'hôpital il y a un an... Ça c'est un rétablissement pour moi, d'arrêter d'aller à l'hôpital…C'est positif, je suis contente. Je ne veux plus y aller. (Estelle)*
>
> *Avoir la paix! (Liz)*
>
> *Rétablissement c'est équilibre. Être en contrôle, être balancé (Terry)*
>
> *Que ça aille mieux en santé mentale. (Nathan)*
>
> *Me maintenir dans la réalité le plus longtemps possible. (Chris)*
>
> *[Quand one st en rétablissement], on mange des bons repas tous les jours, on prend notre médication, on parle avec les uns et les autres dans la maison. (Charles)*

The service user conceptions of recovery intimate that what they need to be in recovery and to consider themselves to be in the process of recovery is support, a safety net, friends, self-confidence, and insight into their mental health difficulties. However, the significance and the meanings attributed to these aspects of recovery not universal. This makes sense when I return to the beginning of the interviews to the questions "what is important for you in your life" and "what is missing from your life". *Charles*, who is in his late forties, reveals that he is a social person who likes to go outside and take walks, but that he is actually living a very solitary life in a boarding house where basic needs such as meals and laundry are provided. He says he would like a job to stay occupied because the other people living in his boarding house are sad and negatively affect his moral. So although he lives in secure housing in the community and is not longer homeless and living with bed bugs, his living situation is not acceptable or helpful for his well-being. Another person, *Chris*, who is in his sixties, explained that he studied literature and social work at one time in his life and although those interests remain significant, what counts for him now is having a safe place to live. He explained that in his former housing unit he never felt safe because the police were constantly arresting neighbours "*parce que [mes voisins] étaient fous*". In his calmer, more secure housing, he says that he can focus on reading and writing and that he feels he is fulfilled in his life. Another service user, *Liz*, who is in her early twenties and lives in an institutional residential program, told me that what counts for her is being physically and mentally healthy. She says she likes to shop and that she hopes to have her own home and to be able travel outside of the city, to a rural setting in nature. So for her, to be in secure and safe housing, and also to be reconnected with her family, is not significant enough to feel like she is in the process of mental health recovery. Finally *Nathan,* who joined the ACT program when I began the field work for this study, explained that he has had an eventful year, which has culminated in some stability and time to work on himself and his life. He says he hopes to find work and a girlfriend before he turns forty, but he is willing to wait until he can maintain his stability.

Recovery was seen as a vague process that was up to them to do, given the right combination of supports to allow for it to flourish, including appropriate interventions for their mental health difficulties:

> *Alors moi je pense que le cheminement se fait seul…Finalement c'est à moi-même de faire mon rétablissement. C'est sûr que j'ai besoin d'un TS pour, disons, aller visiter des endroits, des centres de jour, pour m'occuper l'esprit. Disons que vous êtes une béquille à ma maladie finalement (Charles)*
>
> *…est-ce que l'intervenant peut m'aider là-dedans…je pense que, je ne sais pas. Je pense que c'est plus moi qui peut faire en sorte…c'est plus à moi de faire en sorte que je ne retourne pas à l'hôpital. (Estelle)*
>
> *Je ne sais pas, je ne comprends pas vraiment…mon père m'aide vraiment à prendre conscience que je suis en rétablissement… Il faut que les choses que tu fais, ça devienne acquis. À posséder assez d'acquis pour vivre sans avoir de problèmes (Liz)*

This is a perspective that was also articulated by one of the psychiatrists who said;

> *…le processus de rétablissement c'est un processus donc on est là pour faciliter puis allumer la flamme et souffler dessus. C'est un peu ça, c'est un peu plus ce rôle-là. C'est moins programmé. Je pense que si c'est une intervention…s'il y a une intervention qui est faite par l'équipe on est un petit peu dans ce paradigme-là. À un moment donné, on dit : on arrête de faire les choses pour les gens. Si les gens ont des projets, on les amène à les élaborer donc ça, ça peut être notre aide. Après on les amène à passer à l'action mais l'action leur appartient. Ils peuvent utiliser le téléphone ici, l'ordinateur ici. (John)*

The role of mental health interventions was seen as crucial to providing enough stability so that service users can recognize themselves and make decisions that are favourable to their own dreams and aspirations. Thus, the role of the relationship with service providers, as well as the effects of pharmacological treatment, was valued as a foundation for this individual process of recovery:

> *Une personne qui est en processus de rétablissement, c'est une personne qui doit être conscient de ses épisodes psychotiques paranoïdes ou autres et qu'il travaille là-dessus avec les intervenants. (Chris)*
>
> *Une personne qui n'a aucun rétablissement, qui n'a personne autour comme quand j'étais dans la rue finalement, je n'avais personne autour de moi. Je n'avais pas d'intervention pour ma maladie. (Charles)*

> *[être en rétablissement c'est] de sentir que je ne suis pas trop fatigué, anormalement fatigué. De sentir que je ne suis pas trop insisté. Que vraiment je me sente en contrôle de mes émotions. Que je ressente en moi que ça va dans le bon sens. Quand je sens que les pôles m'ont quitté et que je suis au milieu, que je me sens bien, que je me reconnais, là à ce moment-là je sais que le rétablissement va dans le bon sens… tu es malade, tu te fais soigner et tu recommences…Pour moi la maladie mentale que j'ai ce n'est pas négatif, c'est un plus. Sauf quand je ne prends pas mes pilules. (Terry)*

The above citations and descriptions indicate that the service users have a nuanced approach to recovery that is not necessarily in contradiction with a model of care that is concerned with symptom reduction and appropriate medication adherence. However, their hopes, dreams, and expectations of life belie the asocial and the apolitical: transforming the communities and the lives of service users so that these dreams 'to not be alone' (*"… ne pas être seul ", Charles)* become a reality. The service user participants frequently cited the importance of or to have friends, family, and quality safe housing and social networks,

> *Une stabilité de logement avec de bons voisins, de bonnes voisines parce que des fois le voisinage ce n'est pas évident mais là, ça va bien. Ça c'est stable pour moi. Avoir un réseau social aussi, avoir des amis, de la famille. (Estelle)*

and the importance of being able to create meaningful connections in society outside of the normative path of the labour market,

> *Je ne travaille pas moi présentement. J'ai du bénévolat mais je ne travaille pas pour de l'argent et une chance parce que ma convalescence me permet de cheminer. Je ne serais pas capable de faire ces belles rencontres là et d'aller marcher dehors si je travaillais (Terry)*

These positions and concerns on the part of service user participants are possible indications that social inequalities are barriers to their sustained mental health, well-being and ultimately their full participation in their own lives and in society. The references to housing and the insecurity about living in emotionally or physically unsafe housing speak directly to a lack of social and economic resources that are not formally seen as part of the purview of psychiatric care that still relies on individual interventions. In other words, when exploring aspects of service user's lives that are important for them and that are necessary for a life of quality, the meaning and significance of being in recovery extends beyond the individualized, traditional constructions of recovery that are present in recent Québec mental health policy.[79]

6.2.2 Service provider discourse on recovery

The team was very open to the idea of recovery and always expressed interest and desire to learn how to evolve their practice towards something that is recovery-oriented. One of the reasons they accepted to participate in the research was a general desire to learn more about their practice and how to improve ACT service users' quality of life, citizenship, and participation.

Interviews with service providers also began with an open-ended question about their professional role and continued with an investigation into their perceptions of service users and their difficulties. After discussing the ACT program and the objectives of their interventions I asked service providers what recovery and hope meant to them and what recovery-oriented practice looked like. Sometimes the term recovery would come up earlier in the interview when I asked about the program's therapeutic goals:

> *C'est de faire de la réadaptation avec eux, tout l'aspect du rétablissement aussi et de leur permettre dans le fond d'intégrer la communauté et d'avoir un projet de vie. Au niveau de notre mandat, c'est de les accompagner dans un projet de vie, de les soutenir là dedans. Idéalement c'est d'aller au-delà de la maladie, d'arriver à stabiliser quelque chose dans leur vie. Qu'ils apprennent à vivre avec ça et qu'ils*

---

[79] This recent mental health policy mostly focuses on hope, personal responsibility, services, and citizenship. Note that measures of citizenship in this policy involve awareness raising of rights of service users, soliciting their active participation, and collaboration with educational institutions. The role and actions related to collective, *macro*, or structural issues such as socio-economic inequalities are recognized briefly on page 7.

> *aillent au-delà de ça et qu'ils puissent développer un peu leurs capacités et leur potentiel. Le rétablissement en soi. (Sue)*

> *Le Suivi intensif c'est un véhicule de réadaptation et de rétablissement. Le traitement est secondaire dans le sens que c'est un préalable souvent pour qu'il y ait un processus de réadaptation et de rétablissement qui fonctionne bien, mais ce n'est pas le cœur de notre action. En fait c'est un élément essentiel mais qui ne devrait pas utiliser beaucoup de ressources…On veut qu'un processus de réadaptation, de reprise à la vie, de rétablissement, on appelle ça comme on veut là, mais de s'intégrer dans quelque chose, de reprendre des contacts familiaux, faire du bénévolat, travail, reprendre les études. (John)*

This distinction, or rather confluence, between rehabilitation and recovery is crucial to understanding the actual practices that I observed. Recovery-oriented discourse is tied to concepts of having and supporting life projects; some service providers explain that it should not be seen in silo or be restricted to normative or "ideological" (*John*) conceptions of community integration; others claim that there are still tensions between recovery as an end result or recovery as a process. Recovery in practice, or rather, responding to the demands to be more recovery-oriented, seemed to be in tension with discursive notions of recovery and the practical reality of intensive, community-based mental health practice with service users that have complex social and mental health problems.

Specifically, recovery was defined or understood by service providers in the following way:

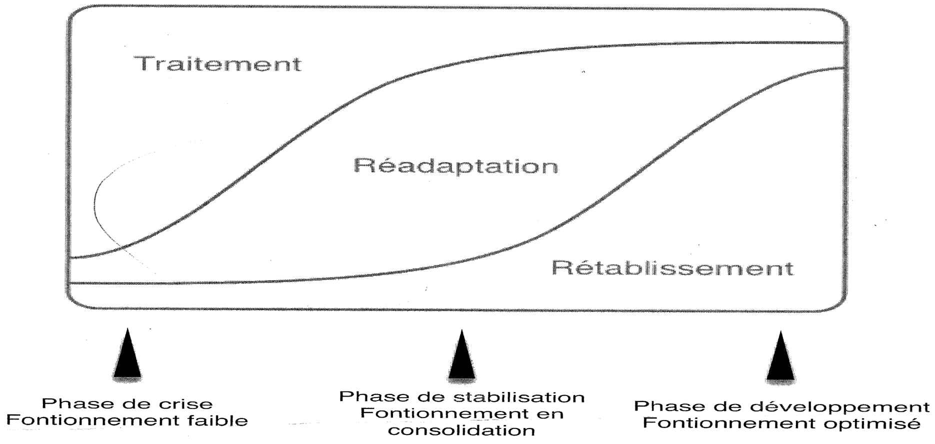
> *Vivre comme tout le monde. Avoir sa place, avoir une vie en parenthèse normale. Ne plus être dans une espèce de moule étiqueté. (Dean)*

> *Ne pas prendre la personne par rapport à sa symptomatologie mais de la voir en tant que citoyen finalement qui a ses besoins et ses désirs et ses limites aussi comme tout le monde. Je pense qu'au départ, c'est la normalisation finalement. La personne souffre d'une maladie mais elle est avant tout citoyenne du pays donc d'organiser la situation de la personne. Après justement c'est d'essayer de mettre son énergie pour bâtir l'espace thérapeutique avec la personne et ensuite essayer d'agir sur tous les points dont on a déjà parlé. (Andrew)*

> *C'est un repère théorique plus large parce que ça inclut l'aspect de ce qu'il se passe dans l'interaction aussi. Je n'ai vraiment pas de façon super élégante de formuler mais c'est cette idée là qu'on laisse à la personne le maximum d'espace pour être plus qu'un patient et quelqu'un porteur d'une maladie finalement. C'est être capable d'aller au-delà des enjeux de maladie finalement chez quelqu'un et de laisser à la personne l'espace nécessaire pour exploiter tout le reste de ce qu'elle peut faire dans sa vie finalement au-delà de l'aspect plus maladie. Je pense qu'il y a un savoir être et un savoir faire qui doit venir avec ça. (Ruby)*

> *Quelqu'un qui travaille dans le rétablissement va dire : 'Bon c'est quoi les étapes de ton projet? J'imagine que ça se planifie. Okay, dans ton plan qu'est-ce que ça implique? Il faut que tu appelles des studios, que tu prennes des pris, des soumissions. Il faut que tu te connectes à un réseau de musiciens, que tu appelles des amis ou quelque chose'. Ça on peut faire ça, suggérer qu'il y a un processus de planification, d'amener la personne à faire un processus de planification pour aider la personne à bonifier son projet comme un ami pourrait nous aider à bonifier un projet comme on se réfèrerait à des gens autour de nous pour améliorer notre projet. (John)*

The above citations underscore values of inclusion, person-centeredness, subjectivity, hope, and space that are congruent with the recovery orientation guiding this research. However, some service providers also explicitly underscored the tensions created by a system in which they operate. Overall the team is influenced by the following schema, which most service providers are familiar with:



This graphic, as explained to me in detail by *John* and *Angus*, was conceptualized by one of the psychiatrists. It is referred to as a way to define the level of care. The schema depicts recovery as a foundational concern, even when the service user is only or mostly receiving treatment (crisis, medication, symptom reduction). As the service user is stabilized and 'functioning' is restored the service provider can move onto rehabilitation interventions such as housing. Finally, in the last phase, all of the factors required for a service user to be in recovery are in place. At this point, once medication is stabilized and housing and occupation are satisfactory, the service user might be evaluated by the service provider as being in the recovery phase if she is working independently towards fulfilling her dreams and goals, typically through the labour market.

> *Quand la personne est rendue à accepter son problème de santé, quand la personne accepte son traitement, qu'il a vraiment une auto critique sur sa*

> *personne, quand elle fait des choses pour avancer alors la personne est en voie de rétablissement. Le processus, c'est le début quand on commence le suivi avec le SI, on est en processus. On commence tranquillement à donner des outils pour que les personnes puissent se rétablir. Quand une personne réussit à se rétablir, le mérite vient d'abord du client. Moi c'est quelque chose que je défends corps et âme. Le mérite vient d'eux d'abord. (Dean)*

Once a service user is evaluated as being in the recovery phase for at least two years (according to psychiatrist, one year according to the official documents and other service providers) she is ready to be transferred to a community follow up or to a less intensive team in order to continue her recovery journey and accomplish the recovery process.

It is interesting to note that the first line mental health team manager and the clinicians who participated in my master's research in 2010/2011 referred to this same recovery schema. They indicated that once a service user reaches the 'recovery phase', in other words, once psychosocial rehabilitation has been accomplished, they are transferred to a community organization (Khoury, 2012). In both cases the mental health team's focus is on restoring social functioning, while community organizations are meant to focus on maintaining recovery afterwards. In addition, in this recovery schema there is also little to no recognition of social precarity regarding access to arts, culture, and leisure activities. Concerns related to poverty, access to education, arts, culture, music, literacy, community engagement, capacity building, family, and friends are perhaps dampened by a recovery-oriented practice that is considered to be accomplished when social functioning, mostly through work or school, is achieved. Many service providers stated, when asked in the interviews, that recovery is accomplished through work. So although certain system-level values of recovery such as participation and citizenship are identified in policy and often in discourse, the context might complicate and muddy the actualization of corresponding actions. In other words, although the recognition of service users living in poverty or being "*poké, magané*" is mentioned several times by different service providers, there are no concrete actions or interventions related to creating the social change that would be necessary to respond to those inequalities. I would suggest that the sustainability of a recovery journey is hampered when social inequalities are not addressed in a collective manner. In fact, that is not the mandate of the team and the overarching paradigm of New Public Management (NPM) does not necessarily sanction acting upon those inequalities. Moreover, the above schema and representation of recovery underscores not only an individual responsibility for recovery that is positioned well within the paradigm of neoliberalism, but also influences recovery-oriented practice to focus on a return to normalcy and reduction in the intensity of care. Thornton and Lucas (2010) suggest that a purely descriptive conceptualization of recovery that considers recovery to be a return to normalcy misses the mark. In addition, there is a strong contradiction between the schema presented above, which intimates an intent for the service to fade into the background of the person's life as they become more self-determined and socially connected, and the actual practice observed in which an intensity of contact is both necessary and detrimental to the establishment of a social network. The complexities of intersectional difficulties and inequalities such as social class and poverty, social exclusion, homelessness, gender, and multiculturalism are not addressed as a whole by the ACT team or the program mandate itself. The ultimate goal of ACT is to make service users autonomous and responsible and they do so by providing a full service and total care for service users in all spheres of their life in order to reduce the risk of hospitalization.

6.3. Participation: bringing the person back to the centre of care?

The critical standpoint guiding this research and analysis deepened my understanding of how participation can animate a recovery-oriented practice. Policy directives in Québec already refer to participation and agency of citizens (Government of Québec, 2005) and full citizenship (Government of Québec, 2015) as underlying value orientations. In the urban ACT team that participated in this study, I uncovered two levels of participation, *macro* and *micro*. In the *macro* sense, participation consists in an engagement with society, without being reduced by normative definitions. I observed service users living in their community, in the world, in various different ways, and this was generally accepted and supported by service providers. However, there were limits regarding the implication of service user's in common social projects, care planning and organizational planning[80]. At the *micro* level, participation is formalized through the completion of Individualised Intervention Plans (IIP). The presumption is that the IIP will systematically encourage service providers to seek the participation of service users in the construction of objectives and interventions.

6.3.1 Individualized Intervention Plans

One way in which the organizational structure has tried to support service providers in focusing on the person and injecting the notion of participation into daily actions and interactions is through the development of the IIP. The team lead advocates for this participation and even told a nurse on one of the admitting units that the service user should be part of the team (*"La personne usagère fait partie de l'équipe", Christine)*. Although this

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[80] The MHAP 2015-2020 named Citizenship as its first orientation and articulated it as the maintenance of desired social roles (p.13) with measures including active participation of service users and their entourage and including service users in the planning and organization of services

may not always be practiced in a concrete way, perhaps because ‘buy in’ to changing practice in this way is not yet accepted by all stakeholders, it is evident in her value system and the value-driven practice that she tries to transfer to her team. Not only are factors like the flat and flexible organizational structure, and the specific values held by some key service providers strong counter forces to the impetus for measuring and objectifying, but so are some tools, such as Individualized Intervention Plans (IIP). Nevertheless, the analysis of the interviews underscores the fact that the IIP is simply a tool and the way in which it is used impacts its effectiveness. This highly quantified tool can be completed at a strict minimum and only provide service users with a metric associated to key indicators of well being such as spirituality and social network. When it is completed with a more qualitative perspective, the scales can be used to have access to more information and open up a conversation with the service user. The relationship is affected, the interaction changes, and there is opportunity to have a better understanding of the service user’s subjective experience. In essence, this tool has the potential to create a space for dialogue. When Linda Bourgeois discusses open dialogue in Rodriguez et al. (2006) she describes it as a way to enter into a relationship with another person in order to have a constructive communication on difficult and complex topics. In a similar vein, Dewees (2002) believes that change, resilience, and hope are nourished through social interactions and dialogue. To do this it is imperative to consider: the voice of the service user; the social relationship and power dynamics between the professional and the service user; the personal journey and narrative of the person in distress.

One objective of the IIP is to ensure service-user led mental health practice; thus the centrality of this tool in the MHAP and within the ACT team, as per the CNESM requirements, to shift the position of the service user from a passive player to an active participant. The development, conception, and implementation of interventions based on an IIP is supposed to be co-constructed with the service user. The IIPs are completed for each service user and are definitely longer and more detailed than ones I have used and seen in other mental health settings. They are usually completed in one meeting, often at a coffee shop or in the service user's apartment, after the assigned service provider and service user have had some time to get to know each other. I noted that the one page IIP is in essence a checklist with several questions requiring a quantitative answer (ex. on the scale of 1-10 how is your satisfaction with sexuality) with a brief qualitative portion that includes 2 objectives. The IIP does not include space for life goals or life projects but there is a 'dream' section on the big board in the Great Room (note that only 9 service users had something written beside their name). I learned that service users' goals are usually discussed and dealt with verbally and informally. However, when there are concrete dreams or goals the team does try to support them. Sometimes the 'dreams' section is framed by what people do not want (ie. do not want to be hospitalized).

I observed the IIP process on several occasions, and the specificity of how the tool is used depends on both the service user and the service provider who are using it. One day I went to breakfast with *Andrew*, a service provider, and *Terry*, a service user, to complete the IIP. This service user complied with the task and responded to the quantifiable questionnaire including naming his personal objectives. Later, in the research interview with me, he expressed his analysis of the IIP tool and experience:

> *Là, on vient d'en faire un plan d'intervention…mettons qu'il me parle de l'estime de moi, là de 1 à 10, comment tu te situes pour l'estime de soi? Mettons que je dis*

> *6,5. Je ne sais pas pourquoi je mettais des virgules mais 6,5. Là il me demandait : Pourquoi tu dis ça? Parce que j'ai un manque de confiance en moi, parce que quand je suis en relation avec les autres, je veux toujours qu'ils m'aiment. Lui, il écrit ça. Il a toute une liste et à la fin on doit cibler ensemble deux objectifs pour le prochain mois que je préfèrerais le plus améliorer, changer transformer. Là, il va me remettre bientôt le plan d'intervention, je vais le signer et ça va être la marche à suivre pour le prochain mois […] Honnêtement, je trouve que c'est une perte de temps, c'est une perte de papier. On s'en fou des objectifs! Il y en a trop pour commencer. Pourquoi ne pas faire le plan d'intervention sur deux rencontres par exemple?*

Other service users did not feel comfortable with certain aspects of the IIP and that was often respected by the service provider, but also depended on the service provider's value orientation and *ethos*. For example, *Néomie*, a service provider, completed an IIP with *Roula*, a service user. *Roula*'s objectives and dreams were to find independent housing and be rid of the treatment and housing order requiring her to take medication and live on the territory served by this ACT team. *Roula* did not want to complete the quantifiable scale on the IIP until she found independent housing. *Néomie* accepted this and through her advocacy for this service user at the team meeting, the team did as well. On the other hand, some service providers do not always agree or accept the way in which service users complete the questionnaire. When *Angus*, a service provider, discussed an IIP he completed with *Antoine*, a service user, he commented that it wasn't very reliable because "*[Antoine] s'est surévalué partout"*. Certain words used by service users simply did not carry symbolic capital or credibility. For example, at a team meeting *Allison* is reviewing an IIP she recently completed. In the section called Spirituality, the service user wrote "*citoyenneté"* and the team chuckled. His service provider exclaimed, *"il veut faire réagir"*. This example illustrates the failed attempts of the service user to discuss something out of the usual parameters of treatment as usual, something that is not on the agenda yet in an explicit way. In another example, when going through the IIP for *Elsie* at the team meeting, her main service provider, *Derek,* reports that she is sleeping well but doesn't like the medication she is taking because it causes her heartburn. He suggests that her heartburn is in fact psychological and reminds the team that regardless of her complaints or discomfort during her past 2 hospitalizations she needed this particular medication to reduce her symptoms. Therefore, the agreement within the team was to maintain the medication and disregard *Elsie's* concerns. This is not surprising as the program's central objective is to avoid hospitalization and consequently engage primarily in risk and symptom reduction interventions. The result is that sometimes the experiences and perspectives of service users are understated. Thus, the credibility of *Elsie'*s reporting is questioned and when she indicated on the IIP that she is depressed, the team, at the meeting without her, disagreed and decided that she is hypomanic; her psychiatrist claimed that she is in fact in remission. In this way, multiple times, I observed the role of service providers in the framing and definition of the problem, the interventions, and objectives of the service user without the input of the service user. This may account for themes of helplessness that also emerge from service user statements. They will often cede to the suggestion and lead of the service providers in completing the IIP, despite the practical irrelevance of this tool in their lives:

> *On fixe des objectifs, on en jase ensemble et au bout de quelques mois, on revient sur ces objectifs-là pour savoir si on les a rencontré ou pas…[C'est] Pas vraiment [utile], c'est là mais ce n'est pas obligatoire" (Chris)*
>
> *Je suis interpelée mais ça ne change rien à ma vie. Ma vie ne va pas se transformer parce que je vais avoir un travail. Parce que je sens que les problèmes me suivent là. C'est comme si je suis désillusionnée de la vie normale parce qu'il m'est arrivé des choses vraiment dures alors j'ai de la misère à prendre le dessus…* (*Liz*)

So what to make of these observations? The appearance of an unequal partnership or participation between service users and service providers in the development of intervention plans may not initially be a surprise. We already know that the majority of service users in the public healthcare system are marginalized and socio-economically excluded. It seems that a certain type of knowledge and experience is legitimatized within this community-based psychiatric team. Service providers are more adept at mobilizing this knowledge capital in their roles as professionals, particularly medical or para-medical professionals. The conversations, actions, and objectives remain framed by normative expectations of life in the community.

My observation of the IIP process and the dynamics in the interactions raises two main comments. The first is the fidelity with which service users and service providers completed the IIPs, and the second is the reliability with which the IIPs where actually used and referred to as a tool to improve participation and person-centeredness. In an era of recovery in which service user participation has become somewhat formalized and institutionalized through the IIP tool, this perceived negotiation might be seen in differing ways by different participants. Although some service providers expressed a satisfaction with the way tools such as the IIP has helped them to structure their interventions, other service providers such as *Karl* admitted that " *on l'utilise pas vraiment, le PII. On le présent [à la réunion d'équipe] mais on ne l'utilise pas vraiment. On réfère pas à ça"*. When I broached the subject informally over lunch, the service providers that were present agreed, one of them also stating "*on n'utilise pas le Kardex comme faut – c'est très administrative et ce n'est pas très clinique*". This may be a contributing factor to the service providers' sense of helplessness and unease with the combination of coercive practices and participative values in community mental health practice. Is it possible that IIPs may be an obstacle to developing recovery-oriented practice if closer attention is not given to what it means to offer a good quality of practice? A peer-support professional who was invited to present a short seminar on Recovery during a team meeting advised :

> *L'important c'est le mieux être même si cela veut dire rester en chaise berçante dans un appartement moitié propre. On n'a pas besoin de passer par les normes de mieux être comme le travail*

The analysis of the interviews and of my observations underscores the fact that the IIP is simply a tool and the way in which it is used impacts its effectiveness. Instead of interpreting these paradoxes in the very tool that is meant to develop collaboration and partnership between service users and service providers as a sign of failure or a sign of the omnipotence of oppressive practice, I propose to interpret these paradoxes as part of the specificity of the ACT program. The very existence of these contradictions intimates that there is room, there are opportunities, to go beyond a technical service offer and impose a value-laden approach to care, one that might reconfigure the participants' relationship to madness. Thus, the provocative questions lie in explicating, through an analysis of what is done and produced by the actors in an ACT team, what they actually accomplish with the room to manoeuvre that the structure of ACT gives them.

6.4. A two-track recovery approach?

During the period of observation the team was evaluated by the CNESM using the TMACT (March 24 and 25, 2014). One of the indicators in this this evaluation tool is called Full responsibility for providing wellness management and recovery services. This indicator specifically refers to services being so complete within the ACT program that "there is little need for consumers to have to access services outside of the team" (CNESM, 2014). These include the development of Wellness Recovery Action Plans (WRAP) and the use of the Illness Management and Recovery (IMR) curriculum. The team received a score of '1' indicating that less than 20% of service users in need of recovery services were receiving them from the team. The evaluation reported that recovery-oriented tools and approaches were not known to service providers and that less that 10% of service users had met with a peer-support professional.

What I have explicated in this research is the appearance of different intervention strategies in ACT mental health practice. Service providers harness their organizational structures as well as their professional autonomy and knowledge to either:

a) access privileged moments and spaces for potentially transformative interventions, or to
b) interact with service users through techniques that maintain spatial, temporal, and interpersonal stability.

Despite the most progressive intentions of service providers, the recovery process and the construction of potential recovery-oriented interventions is negotiated not only for individual service users but also for groups of service users based on social workers' expectations of that group. Thus there is a two-tiered approach to recovery for service users evaluated as having a capacity for rehabilitation, who are judged as having adequate insight, and another approach for services users that are judged to have low insight and therefore incapable of rehabilitation for the time being. For the former group, the type of interventions that are constructed can be categorized as 'accompaniment' and for the latter group as 'maintenance and safety net'.

This difference was clearly articulated by one service provider who explained

> *Si la personne n'avait aucune introspection…en fait, les gens qui ne se rétablissent pas ici n'ont pas d'introspection. Ils n'ont pas d'autocritique. Ce sont des gens qu'on maintient. Ils ne se rétablissent pas.*

6.4.1 Maintaining stability

I will first discuss the interventions that can be qualified as maintenance. With whom are these types of interventions constructed? The potential for recovery is differentiated by the service providers, but perhaps in a way that limit its universality for service users:

> *Ça veut dire quelque chose de différent pour chaque personne. Chaque personne qu'on a ici va avoir un rétablissement différent. Il y en a qui vont être juste capable d'avoir un chèque d'aide sociale et qui vont être capable de se trouver une maison de chambre et de fumer des cigarettes le restant de leurs vies dans leur chaise. (Karl)*

This research indicates that service providers sometimes have low expectations of service users or they feel helpless to sustainably change the context of a person's life. As aforementioned, acting upon social determinants of health is difficult and not prioritized in the current work organization of public sector service providers, whilst attention is paid to reducing or managing risk and a ensuring return to normalcy. Consequently service providers engage in a mostly unidirectional construction of maintenance interventions.

> *Je pense que tout le volet maintien…en fait maintenir dans la communauté, ça demande à ce que la personne puisse rester dans son milieu. Donc, c'est tout ce qui est maintien du logement d'une part, que ça soit de faire le ménage, le paiement du loyer, le rapport avec le propriétaire, le rapport avec le voisins, ça demande une organisation quand même de maintenir son logement. Il y a aussi répondre aux besoins de base, je pense. Se nourrir, se loger, se vêtir, l'hygiène, comment je vais prendre soins de moi, comment je vais soigner ma maladie. (Derek)*

Recovery is a process and potential outcome for some service users, but not for all, based on service providers' expert assessments and expectations of them. Service users are informally grouped according to the service providers' subjective assessment of them as individuals according to who will receive maintenance interventions or who might benefit from more complex relationship building. For example, when talking about *Boris,* one the psychiatrists explained the intervention strategy to maintain a safety net through weekly phone calls only:

> *on est un filet de sécurité pour lui. Pas de psychoeducation, pas de readaptation,*
> *On maintien contact téléphonique une fois par semaine (John).*

With an objective of maintaining spatial or interpersonal stability, technical interventions that meet basic needs are accomplished. These are constructed in a uni-directional manner with little to no input from the service user and are due perhaps to both internal and external pressures. When a service provider told me in the interview "*On a tellement une grosse responsabilité sur les épaules*", he was referring to the responsibility of taking care of people but also the need to decrease risk "*parce que s'il se désorganise ici on à l'air des clowns*". The focus here was on maintenance and protection, and any notions of the possibility of recovery and citizenship were well over the horizon. For example, the team's goal for *Nathan* was to get him to wash and shower. Three team members went to his apartment to discuss strategies to improve his personal and home hygiene. Perhaps because a larger framework of recovery is not employed, partly due to the systemic constraints that guide the organization of work and supersede the active development of a recovery-oriented perspective, and perhaps due to the casual displacement of the self-determination of the service user in the construction of this intervention, the service providers conclude that controlling the service user's money would be an effective way to get him to shower. Although the leverage proposed though control and surveillance is a source of malaise for service providers, they do it because, as *Robert* stated in his interviews, sometimes they have no other recourse or are at an impasse with very few choices before them. The leverage itself can be interpreted as coercive and controlling when we ask the following questions: Whilst focusing on personal hygiene is a socio-normative concern, is it a concern for *Nathan*? Is it a critical component to understanding his experiences, difficulties, projects, and wishes? However, this leverage can also be understood as encouraging and structuring when we ask: Does this support relationship-building? Are these interactions based on a singular knowledge of *Nathan*? Does this open space for places of contact that have potential to lead to open dialogue? For example, following 5 months of follow up with the team, *Nathan*, for whom a contract was set up to help him attend to his personal hygiene, arrived at the office to obtain his money. He looked different with a haircut and new clothes. He had gone shopping with one of the social workers. Another psychoeducator explains that meeting with him is more pleasant, as he doesn't smell anymore. With a behavioural intervention of using a reminder system on a calendar in his apartment he is independently washing his clothes and showering. When asked about his relationship with the service providers he responds *"Ça va super bien. Ça va mieux que quand j'ai commencé. Ça va de mieux en mieux.* ». The positive significance that *Nathan* has for the team, the strong relationship and therapeutic alliance that has been constructed, is evident in his affinity for them through his actions and his words.

Another example involves *William* whose complex difficulties include substance use. The team agrees with the psychiatrist who states that *"l'objectif avec lui sera de maintenir l'adhérence au traitement"*. With this intervention goal in mind, the team brainstorms ways to meet this objective. Because he is placed in the group of service users with complex problems, the objective becomes maintenance. But since he is also judged to be collaborative with medication, there is no need for recourse to more coercive techniques such as treatment orders. Instead, they discuss different substance use programs that could be useful and ways to more effectively manage his money and his debts. This is an individual whose money is managed by the public curator; one service provider suggests that he be moved to a rooming house that will be less expensive than his current apartment. The intervention plan for *William* does not extend beyond the management of his finances within the framework of the public curator's mandate. The decision to 'maintain' his medication adherence implicitly excludes him from experiencing more complex and in-depth interactions with service providers that might also serve to construct more profound relationships and interventions.

The hopelessness and helplessness expressed by service providers was typically in the context of being incapable or unequipped to sustainably change the circumstances of service user lives. Sometimes, however, that hopelessness stemmed from the imprint of traditional, psychiatric norms, namely a Kraepelinian perspective of chronicity and downward spiral in schizophrenia. *Jack* is a young man for whom many team members had a strong affinity and who was known for spending his days travelling the metro system. This was acceptable for the team as he did not disturb or bother other members of society in his daily routines. However, he was recently hospitalized following a resurgence of substance use and was described by one of the social workers as unmanageable and disturbing. This social worker recently cut off his phone in the hospital because he was calling the clinic up to five times a day. He referred to his meetings (on the admissions unit) as "*super utilitaire*" because it is hard to understand what *Jack* is saying and difficult to decode his words. The team reflects with sadness about this change in a service user whom they considered engaging and within whom they identified a potentially successful outcome. Understanding the inherent ebb and flow of the recovery process, and the re-framing of crisis, admissions, and periods of mental ill health may have been helpful for the team to not give up hope. Instead, *Jack's* psychotic episode is explained as "*toxique par manque d'usage du cerveau….il apparait avoir une décompensation, presque une démence*" (*John*). This is not an isolated perspective, albeit not expressed by all service providers; one of the nurses referred to another service user's situation by explaining that he is a lost cause: "*il va rester à l'hôpital tout sa vie. Il y a rien à faire avec lui*". One of the social workers agreed saying "*Il aime bien l'hôpital au 4AB*" (this is a unit where service users pay $180/month). The perspective of chronicity and hopelessness and helplessness were palatable and served as evidence for the team to adopt maintenance or technical interventions, with less emphasis on dialogue and relationship building. In fact, the idea that service users need to be deterred from staying in the hospital was pervasive: When speaking about both *Jack* and *Melanie* different service providers explained how they need to make sure that they are limiting the service users' day passes and gym privileges in order to "*bien vendre la sortie [de l'hôpital]*" and because *"je ne veux pas qu'elle à le gout de revenir à l'hôpital*". These concerns or hypothesis were not verified with the service users in question and speak to the ways stigma and discrimination have been structured into our institutions, partly through daily actions and interactions among actors in a mental health team, despite the good will and professionalism of many workers. Moreover, these examples also provide some insight into the role of social determinants in the construction of mental health, recovery, and recovery-oriented mental health practice. Social inequalities tend to be considered as relevant, but distant, unexamined background noise in current organizational and professional structures.

A final example of the two-tiered recovery approach involves *Mike* who has a long history of living in a situation of homelessness. When he was recently discharged from a hospital stay he was placed in supervised housing by the ACT team because he is under a treatment and housing order. However, he prefers to live on the streets and thus does not often sleep at the resource. When he does not sleep at the resource he is not available for *Med drop*, but he does go to the ACT office to collect his money that is managed by the hospital Trust. However, the team is reminded that the contract they agreed upon with him is that if he does not sleep at the resource and thus is not available for morning *Med drop*, they will apply the treatment order and call the police to find him and take him to the ER. Past experience with *Mike* demonstrates that when he is living in the streets he doesn't eat well, doesn't attend to his personal hygiene, and overall cannot take care of himself. Thus, there is an increased risk of hospitalization. The team reiterates their goal of maintaining his spatial stability by keeping him in the resource even if he doesn't want to live there.

6.4.2 Accompaniment

Accompaniment is a term used in the alternative community mental health sector (RRASMQ, 2009). It can be understood as a form of support and aid in which one person connects with another in order to assist the latter in approaching a goals, project or wish. The crucial aspect of accompaniment is that the rhythm and pace of the person must be respected and followed. Karsz (2004) reformulated this philosophy when discussing the importance of moving away from a *prise en charge*, that is to say a professional who owns knowledge and does interventions onto an individual or group, to a *prise en compte*, that is to say placing in a central position the knowledge, experience, and unique contributions of the individuals or group that the professional is working with. The meaning of accompaniment within the realm of a traditionally patriarchal, class-based, pathologizing, expert-orientated structure manifests paradoxically. When discussing these potential paradoxes in the framework of institutional accompaniment, one service provider told me during a brief, informal conversation that accompaniment is further complicated by the limits in the abilities of service users. This implies that those abilities and their limits are determined by the service provider and are considered as inherent in the individual service user.

When the service providers have higher expectations "that a person can recover" because they are young, have family, are engaging or are judged to be insightful or they do not have complex problems such as substance use and homelessness, then more complex interventions related to social integration are employed and are sometimes even co-constructed with the service user. When a service user is informally categorized into the group of service users for whom there is a higher expectation for positive outcomes, it is because they are judged as having good insight and thus the capacity for rehabilitation and recovery. Herein, I observed interventions that are described by the team as 'accompaniment'. *Chantal* has a university degree and is described as "very motivated to find a job". *Dean* tells me that even though she has moved out of the territory, she represents such a hopeful case that she is still followed by the team. The team of service providers, who have reported feeling like they are the end of the line for many service users and must thus engage in coercive practices to maintain their stability, are professionally relieved when they have the opportunity to engage in more complex interventions, usually related to work or school. In the case of *Chantal* her main service provider has been investigating job resources in her new territory and will even accompany her to *Emploi Québec* offices in her sector.

Another example is with a new referral who was described by the social worker and psychiatrist who evaluated him as *"un bon schizo, quelqu'un malade. Une vraie schizophrénie*" but without any substance use or personality disorders to complexify this situation. Thus they reported to the team that this was an exciting new person to add to the caseload because

> *Au niveau de réadaptation il y a quelque chose à faire. Il est allumé, il veut faire plein de choses. Il a passé 8 ans dans la rue sans traitement. Il veut parler maintenant. Affectivement, il est présent. Il est structuré autour des activités et pas autour du dialogue.*

The other psychiatrist added that he is "*sur le cocktail Abilify et Clozapine que je prescrit à tout le monde*". This was a rare case presentation in which a community mental health organization, PRACOM[81] was already identified as a potential community resource and point of integration.

This "two-track" recovery approach recalls critiques of psychosocial rehabilitation programs that only placed service users in vocational training programs once symptoms were reduced. Davidson et al. (2001) cautioned that people in prevocational training programs are continuously told to fulfill prerequisites of being 'normal' and never enter the job market. In a similar way, ensuring that a service user is functional enough before offering more complex accompaniment services that support her recovery not only supports a deficit-based approach that is about remediating weakness but is also disempowering as it maintains the practitioners in the position of decision maker and expert. It points to a professional and expert-driven dominance over the meaning of recovery and excludes questions related to social inequalities, social precarity, and social determinants of health that acutely shape and influence mental health and well-being. Moreover, access to services or activities that might open a path to new

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[81] PRACOM is a day and evening centre for people living with mental health problems in the centre-east sector of Montréal. It is a community organisation that offers a varied program aiming to satisfy personal desires, develop or acquire daily living skills and create individual transformation through an inviting, positive, and healthy community space. As with all organisations that are members of RRASMQ, PRACOM emphasizes empowerment, recognition, diversity, pride in singular experiences, and humanity. (PRACOM, 2017).

skills, learnings, or interest and can help a service user build a life of quality in the community is also excluded or marginalized. In short, the usage of a two-track recovery approach, with recovery-oriented practices entrenched in a normative institutional accompaniment, unearth the invisible aspects of power in operation in this institutional conceptualization of recovery.

6.4.3 Negotiating outcomes for service users

The two-tiered recovery approach represents a paradoxical institutional arrangement of accompaniment that remains highly individualized and relegates social inequalities to an unexamined background reality. Complex social problems such as homelessness are addressed more directly through the development of new organizational structures (PRISM) and approaches (street psychiatry) with the goals of providing solutions to individualized mental illness through medication and housing. Although this outreach is a first step to connecting and building a relationship with certain people experiencing distress, the framework of recovery is not a consideration or used as an orientating approach. Social interventions, both for those service users who are to be maintained in their stability and for those who are grouped into the category as having potential for transformation, are lacking a broader concern for social and collective concerns. As I have noted throughout the last 2 chapters, service providers often cite the organizational constraints and the subsequent legal, medical, and administrative pressures as the most influential factor in the way interventions are conceived and constructed. These constraints and pressures lead to a focus on symptom reduction, harm and risk reduction, avoiding hospitalization, maintenance in the community through housing, and improved social connections/cohesion. The complex social difficulties and inequalities faced by the service users are often through interventions shaped by purpose rather than process and lead to recovery being reconceptualized into an individual responsibility. The context in which that individual must take responsibility for her recovery process, both socioeconomically and clinically, is not a predominant consideration. In other words, if a person such as *Liz* is experiencing feelings of hopelessness, marginalization and also living with the effects of poverty and stigmatization, within the ACT context she is able to establish therapeutic relationships that support and accompany her in finding housing, managing her substance use, and connecting with her family. However, *Liz* does not report being in a process of recovery because her existential goals are not being met. Moreover, the predominant recovery framework that is employed is one in which *Liz* alone is responsible for her recovery, despite the current context in which her treatment, housing, and certain broader life choices are controlled by the very relationship she developed with the ACT team.

Despite the most progressive intentions of service providers, outcomes are negotiated not only for individual service users but also for groups of service users based on service providers' expectations of that group. That means that some groups of service users are considered to be on the "recovery-track" and more complex interventions are envisioned, whilst other groups of service users, usually those with more complex problems, are on the "maintenance-track" and more technical interventions are accomplished. The unequal outcomes by level of distress or suffering suggest that stigma or discrimination has become structured into the ACT program, and the parent institution, through daily actions and interactions among actors in a mental health team, despite the good will and professionalism of many workers. Larger structural inequalities are not only constructed, but also maintained within these interactions because service users and service providers are mobilized to accomplish tasks within the public space, outside of the institution, rather than to transform it.

As aforementioned, some service users indeed expressed dissatisfaction with their recovery process and with the diluted programs and practices, possibly due to a normative model of integration (Poirel et al., 2015). However, the service users do not hold the ACT team itself accountable for that, possibly due to the relationship and therapeutic alliance that is developed with the service providers.

Responding to groups with complex needs: legitimizing coercive practices?

During several team meetings there were continued deliberations about the specific goals of this particular ACT team, especially in consideration of the territory they serve – a city space that is dense with complex social problems. Often, several team members asked "how do we do recovery with the constraints of a coercive system." The team lead spoke in detail of this tension in her interview:

> *Qu'est-ce qu'on pourrait faire de plus ou de différent…en fait moi ce que j'aimerais un jour arrivé à faire de plus, c'est enlever la coercition qui utilisée parfois. À cause des ordonnances de traitement, d'hébergement, du TAQ, c'est très difficile ce bout là je trouve. D'utiliser ce moyen là pour amener quelqu'un à suivre un traitement, je comprends tout le principe du médecin en arrière de ça ou des fois c'est pertinent quand la personne vit beaucoup de psychoses ou fait beaucoup d'épisodes, se retrouve toujours à l'hôpital à un moment donné, c'est correcte mais ce qui est difficile c'est qu'il y a des intervenants qui peuvent utiliser rapidement ce moyen là de coercition et c'est là que j'ai un petit peu de difficulté, ou de ramener rapidement à l'hôpital ou le côté médical des fois qui peut être trop présent aussi. De laisser aller un peu les personnes dans leur expérience. Qu'on soit là encore un peu plus pour ces gens là. C'est-à-dire qu'on augmente l'intensité, on fait différemment. Comme là, on commence tout juste à utiliser un plan de crise mais on est comme mal habile. On l'utilise dans des moments de crise pour voir avec la personne ce qu'on fait alors il faut prendre le réflexe de l'utiliser avant qu'elles arrivent. Ça pourrait être un moyen probablement pour éloigner un petit peu la coercition.*

One of the psychiatrists suggested that as a specialized team that requires a high service provider to service user ratio and that often performs essential tasks outside of the evaluation metrics, they risk being "forgotten" by their parent institution. He explains that the population they serve has new and complex problems not typically faced by traditional ACT teams, which is why he spends a lot of time lobbying the government and fellow decision makers to consider the specialised and differentiated practice required to work with a population of service users living in a situation of homelessness.[82] Meanwhile, the service providers are sorting out new challenges/realities with the homeless population that they are working with given the end of At Home project as well as clients from the new pilot project PRISM. Several service providers on the team (*Christine, Néomie, Angus)* also worked on the At Home project with this specific population. During the team discussion on January 14, 2014, it was concluded that the ACT team must make contact with service users before they leave the PRISM services in order to ensure continuity of care. The team leader articulates that these complex social issues faced by the service users or potential service users require them to adjust their mode of functioning to focus on the social, rather than the medical. She remarks:

> *Dans ce contexte d'itinérance on n'a pas besoin de médicaments pour faire des liens. C'est une approche ici, maintenant. Parce que la solution dans la rue c'est rapide*

During the team meeting on February 4th we hear someone screaming in the waiting room. It is a homeless service user who had an injury and who consumed an excess of drugs. The whole team went out to investigate but they maneuvered like unit, like a well-oiled machine. No one was in anyone's way. No one wanted to play the hero or be in charge. Since it was determined that she was physically well and safe, the security guard invited her out for a walk.

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[82] In 2015 a new ACT team, Homeless ACT, was opened in order to exclusively respond to the needs of that population and to provide a space for service providers to intervene and construct relevant interventions

However, the team lead had trepidations in light of the recent murder of a distraught homeless man the previous day. She says "*L'itinerance c'est l'intensité. If faut être avec eux"* and questions their ethical responsibility in returning this person back to the streets in her condition. Another service provider responds by saying *"on ne peut pas tous les sauver"* to which the team lead replies "*Oui mais elle est déjà suivi par nous".* Implying, and imposing, a certain level or responsibility for the well being of this person during her visits with staff and in her life in general.

The varying complexities of social scenarios reminds the team lead, a social worker, of the role of psychosocial elements in the vulnerable and marginal situations that the service users find themselves. This coercive nature of ACT, discussed in chapter 1 is not experienced in the same way by psychiatrists, service providers, and service users. For example, during a short team conference on the Recovery Model[83], one of the psychiatrists shared his perspective that coercion is necessary to help a service user get out of a situation of social misery and that only once out of that situation the person can experience a sense of self determination:

"*there is always room for both coercion and working with the person*" (*John*).

The invited speaker offered an expanded vision of mental health care, anchored in a social perspective. He explained that it is important for service providers not to underestimate difficulties related to poverty "*sometimes [poverty] is more difficult to overcome than psychiatric symptoms"* and "*don't forget that a person, even when they are suffering, has strengths and capabilities*".

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[83] On January 21st the weekly team meeting included a presentation on recovery from a professional peer support worker engaged by the Institution.

The other psychiatrist on the team expressed some distress at having to juggle the biomedical paradigm and more progressive person-centred approaches. Fundamentally however, she suggested that the coercive practices, which are anchored in the traditional psychiatric philosophy, are a status quo that must be worked around rather than revoked:

> *…mais comment composer avec l'aspect plus coercitif aussi qui vient avec notre travail…, honnêtement, je trouve ça déchirant souvent cette partie là, je trouve ça difficile. Récemment, depuis quelques mois, je trouve ça particulièrement difficile de me positionner confortablement entre ces différentes…dans le fond, c'est difficile de doser la coercition et l'effet de pouvoir rendre des libertés et des responsabilités à des personnes pour qui on sait que c'est difficile. C'est un peu un défi. Je ne veux pas nuire à la personne. C'est une clientèle qui est évidement pas toujours facile, la partie du risque ultimement est complexe*. (*Ruby*)

One of the service providers, *Robert*, explained that he justifies the imposition on service users that his role as an ACT service provider requires by framing it as a way to force collaboration. He tells me what he might say to a service user that is refusing medication:

> *Là, je t'ai vu avec la médication, avec un suivi plus intensif, tu étais bien, tu n'as pas décompensé, tu n'as pas séjourné à l'hôpital'. Le patient est toujours ouvert. Je n'ai pas l'impression qu'on est trop coercitif par rapport à ça. La personne participe. Il y a des moments où on l'impose mais avec une façon de l'imposer.*

Other service providers echoed the sentiments that "*there is no choice with an ACT clientele but to be coercive*". Another example occurred in March 2014 when at a team meeting they were discussing *Susy* who refused all medication. The psychiatrist reminded the team that they have the tool of the treatment order that is in place. He suggested a meeting with her so that he could inform the service user "*si tu refuse le medic, on te pique".* This rhyme elicited a chuckle from most of the team, but in reality the service providers expressed a discomfort with the focus on medication and symptom reduction and a sort of exasperation with a perceived lack of options. Many service users are under psychiatric treatment order and the ACT mandate is to supervise their medication, involuntarily.

The team lead offers a softer approach to the tension between coercion and collaboration. She explains that the coercive nature of the ACT program, engrained into its very *raison d'être*, requires the service providers to be "*strategic in their negotiations [with the service user] so that the outcome is in the service user's advantage*". This is often accomplished by 'striking a deal' with the service user. For example, there was one situation in which there was the possibility for Youth Protection Services to re-enter a service user's life and possibly remove her children. The psychiatrist suggested to the service provider that this threat could be used as a therapeutic advantage and be part of the team's discourse with her. Specifically, the team agreed that they could offer this service user *"a leave from work in exchange for daily visits from the team*" in order to be able to keep a closer eye on her.

Medication as a way to force/create a relationship

Acknowledging that the treatment orders and psychiatric evaluations often give very little choice to either service user or service provider, the team does show a willingness to be creative and work around the impositions that are usually medically focused. Most of the service providers stated that they disliked the medication focus part of their job and find it to be technocratic and often forced. The team lead explains how she works around this professional dissonance:

> *Comment on peut travailler ensemble sans que ça soit trop présent dans nos interactions avec la personne quand on va la voir par exemple cinq jours semaine. On essaie de le regarder, même avec le médecin, est-ce qu'on peut réduire à trois jours et y aller le matin au lieu d'y aller le soir. On essaie de regarder ça avec la personne, on essaie de négocier. C'est sûr que nous notre*

> *travail aussi c'est de refléter dans nos visites cinq jours semaine par exemple, une personne qui ne veut rien savoir de nous, de ne pas juste être là dedans, de temps en temps allé déjeuner. Sortir de cette routine là et de venir lui rappeler qu'elle est malade finalement. C'est aussi négocier ça… De laisser aller un peu les personnes dans leur expérience. Qu'on soit là encore un peu plus pour ces gens là. C'est-à-dire qu'on augmente l'intensité, on fait différemment. Comme là, on commence tout juste à utiliser un plan de crise mais on est comme mal habile. On l'utilise dans des moments de crise pour voir avec la personne ce qu'on fait alors il faut prendre le réflexe de l'utiliser avant qu'elles arrivent. Ça pourrait être un moyen probablement pour éloigner un petit peu la coercition.*

Service providers and service users made the assertion that focusing on symptoms and medications and even reverting to hospitalizations is 'the easy way out'. The team lead suggested that her professional standpoint, which is a result of her professional and personal experiences, has made her realize that :

> *"nous avons tous besoin de flirté avec le risque….je n'ai pas peur de la folie et donc j'ai accès à la folie quand je rencontre les gens".*

One service user, who had a particularly strong affinity for the team lead explained why he understands ACT to be a hospital without walls; in the community:

> *…un organisme qu'on pourrait appeler l'hôpital sans murs car on est dans la ville. On vient vous voir…c'est la première fois que quelqu'un me comprenait, me tendait la main et me disait : On va s'occuper de toi*" (*Terry*)

However, this very positioning as an institution within the community perpetuates practices and discourses that are strongly positioned in the risk reduction camp. Even the team lead, who is 'not afraid of madness', explains in her interview that a major part of their job is to reduce risks so that the person is not hospitalized.

The relationships, the therapeutic alliances, the community housing, and the social networks that are developed in the ACT structure are not created only within the confines of the 4 walls of the ACT office. They are also created and developed on the street, in the bus, in cars, in apartments, in short, in circulation in the community. These relationships, that are amicable and sometimes even affective, are bound by the professional role of the service providers. In essence these are institutional relationships that are uniquely joined at the locus of the human condition, juggling the reality of implicit control through medication and explicit trust building predicated on the acceptance and facility with madness.

When *Derek* discusses a service user with whom he is having difficulty developing a therapeutic alliance, his colleague *Dean* suggests "*il est insecure"* but *Derek* disagrees and responds *"il est fatiguant, il réveil mon anxiété*". In order to manage the situation and his own anxiety, he suggests that the service user needs his medication revised. Risk management is such a central tenant of practice that when a service user expresses new symptoms that create discomfort in the team the response is typically "*il faut le faire voir par un psychiatre avant qu'il décompense" (Allison)*. Since most of the relationship building is a long process and happens through the aggregation of interactions during the short period of time in which service providers drop off medication in the morning and/or at night, it is important for them that service users be present for the *Med drop*. In several cases they applied legal treatment orders (meaning they called the police) when a person was not regularly present in their apartment at the designated time for a *Med drop*. Sometimes treatment orders are newly introduced in order to initiate the development of daily contacts. For example, when the team decided that *Nathalie* needed a better framework of care, they decided to make an appointment with the psychiatrist to explain to her that if she does not show up a treatment order will be put into place.

There are moments in the team's discussion where social inequalities are discussed and lamented. The team talks about a service user, *Sammy,* who is a recent immigrant, a visible minority, and who spent many years living in in a situation of homelessness in France. They are concerned that his insight is impaired because his IIP objectives include finding a job, which they judge as unrealistic. The team concludes that the psychiatrist should see him to re-evaluate his medication. However, in this case, the psychiatrist suggests that on top of looking at his medication they investigate alternatives to employment such as volunteering. This leads the team into an interesting discussing on the effects of self-stigmatization and the role of social factors and social determinants on the lives of service users. In a transdisciplinary team such as ACT I observed constant communication and teamwork amongst the service providers. I also observed a shrewd awareness of the devastating social inequalities that negatively impact the lives of service users. The ACT space is a very dynamic space that is in constant motion and that gathers the perspectives of many different people and professionals. As one of the service providers stated in the interview

> *Ça c'est une limite au niveau de la circulation de l'information. Des fois, l'information circule mais au niveau de l'interprétation de chacun…à long terme, avec toutes les petites informations sur le déroulement des journées ou du suivi avec tel ou tel personnes, c'est plus difficile de maintenir le fil (Angus)*

It seems understandable then that all of these actors would find a meeting place on the common ground provided by the DSM – even if they skirt the use of formal diagnostic labelling. Can actors in an ACT team recognize the experience of suffering and also focus on social inequalities that perpetuate and maintain that suffering?

One of the strengths of the constant tug of war the ACT team experiences, whether it be about what they do with the flexibility the program accords them, or how they use tools and professional autonomy to mobilize community resources, or how they respond to social inequalities, is that the dialectic is not suppressed. The service providers constantly juggle with different clinical realities within one system: the biomedical clinical reality, the psychosocial clinical reality as well as a structural community reality. The unique actions and interactions that are possible in this ACT team are not completely immune to the covert psychiatric hierarchy that governs the decisions and lives of service users, but it does allow for the actors to experiment a more horizontal relationship than they would be able to create in the admitting unit or in a less flexible outpatient clinic.

Although social change is not addressed or mandated, specific micro level interventions are distinguished based on the service provider's assessment of a service user's potential for personal change. This is accomplished though a dialogical process *per se*, which might account for the inexistence of collective action toward fundamental social changes that would improve the lives of service users. Thus a possible explanation for the program's objective of avoiding hospitalizations, but not necessarily working towards alternatives to hospitalization that aren't pharmacologically based.

Services and approaches in psychiatry are often called upon to offer support or to maintain stability (mental, interpersonal, economic, spatial, or other) of the service user. Accompaniment practices more typically associated with community or alternative mental health resources are experiences of individualized interventions focused on the needs and wishes expressed by the service user (René et coll., 2010). As such, accompaniment presupposes a diversity of interventions and approaches. This perspective is primordial to the accompaniment as developed by community resources in Québec in order to support an individual and respond to their singular needs, desires, and dreams. Accompaniment in this ACT team emphasizes supporting and maintaining life in the community, that is, housing outside of the hospital walls. It also emphasizes community-based interactions such as accompanying the service user on errands or shopping as well as on visits to other medical or housing appointments and sometimes to community organizations. Nevertheless, the flexibility inherent in the organizational structure, as well as the horizontal team structure, offers the potential for service providers and service users to construct relationships and interventions that respond to aspects of the recovery orientation, particularly that of individualized actions and interactions based on the singular experiences of service users which require flexibility, recognition, and participation.

Chapter 7: Juggling community focused care in an institutional structure: the role of social actions and interactions

> *"On est toujours le fou des autres, de la société ou de son mandataire: le psychiatre. C'est la psychiatrie qui définit la folie" (Edouard Zarifian, 1994, p.43)*

In the previous chapters I provided a thorough description of the principal mediating structures, work organization, and recovery orientation that frame the service offer and provide context for the actions and interactions amongst actors in this ACT team. In this chapter I propose to analyze what is said and what is done to unearth the actual service offer as well as the actual lived practices and relationships in this urban ACT team. This chapter highlights the intersubjective dynamics within the ACT team, supported by the notion that relationships partially influence the language and discourse that is used (Groulx, 1985 in Jaccoud et Mayer, 1997). This chapter will reinforce the analysis of recovery-oriented practices by demonstrating the ways in which social interactions are mediated by the organizational structure, but it also demonstrate how they are dynamic and varied; they are interactive mechanisms through which discourses, actions, and relationships might be changing and evolving. With a critical perspective of recovery-oriented mental health practice in mind, this chapter will focus on the specific, and often paradoxical, actions and discourses that take place within the aforementioned structures. I will explore if ACT harnesses the flexibility inherent in its structure and in its clinical tools to actualize person-centred and participatory interventions. We know that there are 4 main types of follow up appointments offered within this ACT team, but what really happens during these appointments? How do service users express their thoughts about these appointments and interactions, and to whom? Are the tools used to facilitate development of a relationship with service users? What is the language used by service providers and service users to construct interventions? Are participants distancing themselves from overly medicalized language? Or is illness at the centre of the construction of interventions?

7.1. Engagement with the local community, or the right to exist in public spaces[84]

Community ties are of primordial importance to the structure and philosophy of ACT teams. However, as discussed in the previous chapter, the definition of community is filtered through an institutional lens. A normative short cut to community mobilization and participation is a narrow definition of community as housing outside of the hospital or as resources mobilized when searching for employment or education (Khoury, 2012). The critical perspective adopted in this research is aligned with the rhetoric on citizenship outlined in the 2015 MHAP that encourages mental health programs to: mobilize all partners to do things "together and differently" and engage in collaborative practice with community partners.

In order to really understand the community ties that exist for the ACT program, but more particularly for the individual service users, it is important to consider the way in which all of the actors in the ACT program share the social space and physical space of the ACT territory. In other words, what is their relationship to each other. First, we need to consider the

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[84] those social spaces that are open and accessible to everyone including not just the streets, public transportation, and parks, but cultural public spaces that include leisure activities such as art, dance, or music.

particularities of the lived experience of the service users, all of whom live in precarious and marginalized situations. Every service user discussed a lack of connection with their families, except for *Liz* who recently reconnected with her father after many years living on the streets. Social isolation is a principal challenge and reality for people living with mental health difficulties. This is well-known to the service providers and service users:

> *Je te dirais qu'ils sont assez isolés. Ils n'ont pas beaucoup de réseau. (Christine, service provider)*

> *Ces gens là sont très malades, les familles les rejettent parce qu'il y a un dysfonctionnement au niveau de la famille, c'est certain. (Dean, service provider)*

> *Des personnes qui ont des enjeux au niveau des relations interpersonnelles aussi, soit une pauvreté au niveau de leur réseau social primaire ou des complications dans les relations qui sont existantes, des enjeux assez complexes avec la famille (Ruby, service provider)*

> *J'en ai plus maintenant [de réseau social], mes parents sont décédés. Des frères, des sœurs mais je ne les vois pas très souvent. (Chris, service user)*

Every service user participant stated that they had a non-existent or limited and unsatisfactory social network. By default, as explained by this psychiatrist, the ACT team's reach compensates for this:

> *Je pense qu'on ne veut pas devenir le réseau social de nos patients mais je pense qu'on devient un peu comme un genre de terrain d'expérimentation par rapport à ça. Je pense que les gens peuvent apprendre quelque chose, d'entrer en relation avec des gens par le billet du fait qu'on se voit souvent, qu'ils peuvent apprendre quelque chose là dedans. (Ruby)*

Another service provider explained this more intricately, stating that the specificity and the strength of the ACT team is in its role as a proxy social network for service users:

> *Le Suivi intensif, je remarque souvent, on est leur réseau social. Je pense que c'est là où nos interventions sont différentes. On ne peut pas seulement intervenir professionnellement comme travailleur social avec nos grands mots et nos gants parce que le réseau social de cette personne là, c'est nous. Combien de fois ça m'est arrivé d'aller chez nos clients, un en particulier, il a un Playstation. Je vais*

> *m'assoir avec lui pendant une heure et je vais jouer avec lui, on va parler. Je fais ma job, je la fais ma job. Je fais des interventions mais en même temps j'entretiens le lien et une relation avec lui et le réseau. C'est la communication qu'on a ensemble. La seule personne qu'il voit dans sa semaine c'est moi. C'est très dur. Ces gens là, on en a, qui sont renfermés chez eux 24 heures sur 24, 7 jours sur 7. Ils ne sortent pas, ils ne voient personnes. Ils n'ont plus de contact avec leur famille, ils ont été rejetés de partout. Alors la dernière affaire que tu veux faire, c'est d'arriver avec tes gros sabots. (Karl)*

Service users are aware of the social role that ACT plays in their life:

> *C'est un rôle de soutien psychologique et de soutien financier. C'est comme un réseau social pour moi. (Chris)*

Terry explained to me during a home visit that he considers his mental health care workers from the ACT team and the therapist he sees at another hospital (grief therapy for loss of father, referred to by ACT) as his points of socialization. He looks forward to their visits, as he rarely goes to the clinic himself. When discussing his future with the ACT team he confided: *"J'aimerais qu'ils me suit jusqu'à ma mort"*. Norms related to friendship at a more egalitarian level were also observed. For example, when *Angus* had a follow up meeting with *Adrien* at a hot dog joint, *Angus* paid for the meal. *Adrien* insisted that he pay next time ("*la prochaine fois c'est moi qui paie*") indicated his malaise with a social relationship empty of the usual give and take that is the foundation of habitual social relationships. However, when *Angus* discussed this interaction with the team over lunch, the service providers expressed a discomfort with extending their interactions with service users beyond the technical service offer.

All of these examples illustrate an embryonic, relationship-based practice that begins to capitalize on some of the structural aspects of ACT, namely intensity, flexibility, and community engagement.

7.1.1 ACT as a social network

Every service provider stated that one of the goals of ACT is to help service users create a social network in the community where they live. There is a recognition that each service user is at the centre of her personal social network. For some, it is a network that is individual with the service providers, for others it is also with mental health community organizations or other community-based organizations (ie. collective kitchen), and again for others it is simply found in daily or weekly contacts with neighbours, pharmacy, coffee shops. Service users that were once relegated to the confines of a hospital room are now living in community housing or independent apartments and by virtue of their visit to the clinics or other appointments are more present in the public space then they would have been 10 years ago. Concurrently, the ACT programs mitigate their capacity to circulate and the opportunities to circulate and actively engage in the public space, especially beyond their immediate local surroundings. For example, *Charles* discussed the limits of his ACT follow up in this way:

> *Je dirais des activités sociales, mon social. Je trouve que…comment est-ce que je pourrais dire ça? Je trouve que le côté de ma vie sociale, ils n'ont pas tellement de temps à consacrer pour ça….finalement c'est à moi à m'impliquer. C'est moi qui faut qui se déplace pour aller dans des centres de jour. Disons qu'on passe à côté de ça pas mal. On ne couvre pas les endroits…ou les centres de jour où je pourrais aller passer la journée, faire des activités sociales et tout ça.*

Many of the service providers explained that attending to social precarity, and connecting service users with community organizations, often fails when the service user does not mobilize herself. However, some service providers, such as *Karl,* explained his perspective that the system itself is badly organized to support people living in complex and marginalized situations:

> *…je ne dirais pas le manque de ressources mais le manque d'organisation dans les ressources. Je suis un de ceux qui ne pense pas qu'on manque tant de ressources que ça mais je pense qu'il y a une bureaucratie très lourde et une perte de temps*

> *incroyable. Il y a vraiment un manque d'organisation du réseau au complet qui fait en sorte qu'il y a des lenteurs, qu'on a des problèmes. C'est sûr que le* thinking *que le gouvernement a eu dans les années 80 avec la désinstitutionalisation et de laisser les gens sortir des institutions, pas informer personne et de dire ils vont s'informer, je pense que ça aujourd'hui, ça cause beaucoup de tord. On le voit aujourd'hui avec les sans abris qui sont plus âgés, que ça fait 15-20 ans qui sont dans la rue. Les gens qui ont vécu toute leur vie dans une institution qui se retrouvent dans la rue du jour au lendemain, je pense que ça aussi ça a mis de l'huile sur le feu.*

Despite this, the structure of the ACT program, which is evaluated by the TMACT in terms of vocational and housing support, is actualized in the service providers' actions to inform rather than accompany service users to community activities and organizations:

> *Les gens connaissent beaucoup les ressources mais c'est sûr que si quelqu'un arrive ici et dit qu'il n'a pas mangé, on connait une banque alimentaire pour qu'il aille chercher sa nourriture à proximité d'ici. Il y a des gens qui ne les connaissent pas toutes les ressources donc des fois on peut leur faire connaitre, leur donner des adresses mais j'avoue qu'on va beaucoup donner les adresses mais on ne va pas nécessairement faire les accompagnements. On va les informer. (Sue)*

Andrew explained the ACT team's engagement with the local community succinctly:

> *Par exemple pour les personnes qui changent d'environnement ou qu'on prend en charge après l'hospitalisation pour la première fois, une fois qu'ils sont rentrés dans leur appartement et qu'on…tu sais on peut prendre des cafés à l'extérieur dans leur quartier, pour qu'ils commencent à connaitre leur quartier, essayer de voir s'il n'y a pas des endroits où il peut y avoir des activités bénévoles ou participer à des groupes ou des choses comme ça. Commencer à se créer un réseau social dans le quartier dans lequel ils vont habiter.*

My observations demonstrate that the seeds to creating a social network are usually planted in a substitute social network, a proxy, which is the ACT team itself. The challenge is to ensure that the seed does not remain in the soil of the proxy social network, but rather that, if desired by the service user, it flowers and pollinates other soil belonging to the individual's chosen social network and connections.

When service users are accompanied for groceries, shopping, or to medical appointments, are communities being mobilized to become more inclusive? Are participation and community engagement accomplished? As I have illustrated above, the service providers in this team discussed not just the stigmatization, but the loneliness and marginalization of the service users. When discussing a service user who travelled to Québec City to visit a family member, only to have to return to Montreal when that family member was not home, the team responded by empathetically acknowledging amongst themselves that he is all alone in this world (*"il est tout seul dans le monde", Christine*) and discussing the social isolation faced by so many of the service users. The acknowledgement of this loneliness results in service providers compensating for the role of a family member or friend in order to protect the individual. I will offer three examples that demonstrate how accompaniment, and caring, can become a proxy social network which is both unique in the opportunity to know the singular experiences of service users and which can sometimes become overbearing and paternalistic.

The first example is regarding a service user who does not want or need accompaniment, the second is of a protectionist form of accompaniment, and the third is of a controlling form of accompaniment.

1) A service user recently completed an IIP and self-rated herself as 10/10 on all dimensions. Her main service provider responded to her independence and self-determination by describing her as particular because she is looking for housing on her own and in the gay quarter *("spécial parce qu'elle check des logements sans aide […] dans le quartier gai", Robert)*. *Robert* acknowledges that this is a rare situation as many service users have complex difficulties. I have observed that these complex difficulties often result in feelings of malaise and helplessness in service providers whose worldviews become acculturated to one in which

they have low expectations for service users. Nevertheless, *Robert* also discussed with me the limits of ACT as a social network and, like *Karl*, expressed low expectations of what the mental health care system could offer a service user:

> *On voulait qu'un patient socialise, si je continue à prendre le café avec cette personne là, c'est limité parce que la socialisation ne sera pas totale. Il faut que j'essaye plutôt de l'intégrer dans les ressources communautaires qui peuvent prendre le relai. Donc, le Suivi intensif aussi, dans son rôle de rétablissement est limité. Il fau qu'il soit connecté à d'autres réseau dans la communauté pour que ce rôle là puisse être maximalisé.*

2) a service user tells his main service provider that he received a call from the phone company stating that he ordered a package, the team immediately agreed that they would call the phone company and handle the situation because "[*compagnie téléphonique] peut être malin". The team has a protectionist and even parental reaction, in the context of the service user's marginalized and stigmatized social position, as a way to counter discrimination in society. The possibility of discrimination is a source of concern for service providers who are aware of the potential for abuse faced by the service users. In another example demonstrating a different type of protectionism, *Angus* has a discussion with *Sue* and asks her advice on opening a bank account for a service user who independently receives her entire welfare cheque on the first of the month. The service user in question is responsible for paying her own rent. The conversation, and main concern, is how to manage risk if this individual is allowed to have a bank account.

3) Sammy is unhappy in the room he is renting which is in an unsupervised building with 5 rooms, all of which are rented by ACT service users. Due to the street noise level he wants a different apartment. When this is discussed in the team meeting it is agreed not to search for another apartment and to in fact dissuade him from moving. The psychiatrist concludes that *“il est mieux de ne pas les habituer au luxe trop rapidement”.* Another young man, *Joel,* with a long history of homelessness before his recent connection with ACT through PRISM, lives in the same building. He indicated on his IIP that he also wanted to move, and potentially move out of the ACT territory. One social worker suggests that he is resistant to their interventions because the team is not responding to his projects and wishes. However, in the end the team’s expectation of this service user is that he will only want to keep on moving, and that his “cognitive difficulties” are reason enough not to allow it. The team decides that he belongs to the group of service users for whom maintaining spatial stability, harm and risk reduction, are the current treatment goals.

These stories include themes of paternalism and risk management that are entrenched in a traditional psychiatric relationship. This is better understood when we listen to the voice of a service provider explaining their role as a social network:

> *On devient en quelque part un réseau social parce qu’ailleurs il n’y a pas. Ils [les personnes utilisatrices] refusent des centres communautaires pour aller socialiser, ils refusent de faire du bénévolat, faire un travail de deux-trois heures, tout ça c’est très difficile de les amener pour essayer de briser cet isolement qui est finalement le problème majeur parce qu’ils sont là en retrait social, c’est sûr qu’ils vont devenir plus psychotiques parce qu’il n’y a rien à faire. Regarder la télé, manger n’importe quoi, prendre du poids ça donne des complications, les maladies. Il y a un cercle vicieux. Si tu n’agis pas sur un problème, ça va vraiment ramener plusieurs autres problèmes. (Allison)*

Corin (2002) discusses the notions of social connections and cohesion when referring to the unique experiences of recovery for people living with mental health problems. Her research indicates that what helps people living with mental health problems remain autonomous in their community is the possibility to construct their own space at their own pace. This personal construction of space, at differing rhythms, sometimes results in a chosen social connection which is at once set back from the world but close enough for the individual to reconnect when he wants to. She calls this phenomenon “within and without”[85]. It integrates the possibility for different, marginal types of socialization and social network building.

However, the interactions within this proxy social network can also be understood as a series of invisible, yet potentially transformative actions. Many service users explained that their social workers and the team were their friends, sometimes their only social contacts; a reason to get out of the house. The team or service provider becomes a social network. The paradox being that barriers to actual integration and inclusion in the community are ignored or unattended to by the service providers. Although service providers might feel empathy, compassion and even affection for some service users, clear professional boundaries ensure that the development of a social network is unidirectional. Service providers, often social workers, find themselves in privileged spaces to develop relationships and promote dialogue with services users. These spaces can be in cab rides, walking down the street, moving, having a coffee. During these interactions, small acts of kindness, which service users often dismiss as inconsequential, are interpreted as very meaningful and moving by service users that I interviewed.

> *On va manger, on prend un café. On fait pleins d’activités admettons, on va payer mes amendes, des affaires de même… Je trouve ça cool. Des fois je trouve qu’ils me font des faveurs, des belles saveurs. Ils sont à l’écoute. (Liz)*

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[85] Authors’ translation of « dedans et dehors »

These small acts of kindness, which are not yet included in 'best practices' literature are developed when the dyadic relationship enters into a "dialogue" mode. It is perhaps, as suggested by Linda Bourgeois (2006) a former service user, the first step to self-transformation and social transformation. These small gestures and 'acts of kindness' are perhaps invisible actions and interactions that serve to reinforce a more flexible and participatory relationship, despite the fact that they are not easily categorized into a specific intervention approach. The result of these gestures, interspersed with more traditional and normative indicators of success such as medication compliance, can be observed in the service providers' recounting of *Liz's* story. This is the story of a young woman who went into a detox program, and when she was dismissed from that program and sent back to Montreal, two of the ACT service providers met her at the bus station at 9 pm and brought her to a room they had arranged to rent for her on a short term basis.

> *Je pense qu'une des plus belles réussites qu'on a c'est avec Liz, c'est clair. Il y a un an, on l'aurait cru morte dans une ruelle cette fille là. Je l'ai vu dans des états lamentables, j'ai vraiment souvent craint qu'elle pouvait mourir. Ça a toujours été un suivi qui m'a beaucoup touché parce qu'elle se mettait vraiment à risque, c'est incroyable. Comment tu la vois aujourd'hui, elle était grosse comme ça, avec les bras tout troués. C'était épouvantable et maintenant de la voir qui va à l'école, qui prend sa médication, sa méthadone, qui vit dans le centre-ville, qui a de l'argent et qui ne consomme pas avec. Il y a comme quelque chose de vraiment… Moi je n'y aurais pas cru. Il n'y a personne qui y croyait en fait. C'est d'avoir toujours été là en fait. Même si elle était dans un état épouvantable, elle pouvait toujours venir nous voir. Elle savait qu'on était là. Je pense que ça y était pour beaucoup. Le lien qu'elle a développé avec nous y est probablement pour quelque chose. C'est de lui avoir donné l'occasion de vivre certaines expériences aussi, on l'a envoyé à [centre de désintoxication] ça n'a pas fonctionné. Elle est revenue à l'hôpital et à partir de l'hôpital, on a réessayé d'autres choses. C'est sûr que la médication y a été pour quelque chose aussi parce que je pense que depuis qu'elle prend son Concerta, il y a vraiment une amélioration de son état qui lui a permis d'aller vers d'autres choses. De faire d'autre chose dans sa vie que d'avoir toujours l'impulsivité d'aller consommer et d'avoir juste ce désir là. Je pense que c'est de leur donner l'opportunité de vivre d'autre chose et d'avoir toujours été là dans le fond. (Sue)*

The service user discussed above*, Liz*, acknowledged the help she has received stating:

> *je trouve qu'il remplissait bien la demande. Des fois, j'étais étonnée, ils m'ont donné des affaires qui coutaient cher et je ne pensais pas qu'ils allaient autant s'occuper de moi*

The above example is demonstrative of the way the flexibility of the ACT program is harnessed by the service providers to enlarge psychiatric practice and seize the opportunities for acting and interacting in privileged spaces – cab rides, during a move, sitting on a curb, or shopping for clothes at the thrift shop. This provides the context for not only accompanying the service user but also for taking into consideration how the person ascribes meaning to these small acts of kindness.

Similarly, capitalizing on the ACT intrusiveness and insistence on intervening can be harnessed to understand the singular experience of the service user:

> *mes interventions sont souvent basées sur le fait d'entrer en contacte avec la personne, faire connaissance. Créer le lien, travailler avec la confiance. Là, depuis que je suis là, c'était pas mal centré sur ça jusqu'à maintenant. Après, il va y avoir d'autres choses qui vont s'ouvrir par la suite (Andrew)*

In Furtos's (2007) analysis of the paradoxes of the defense mechanisms that accompany extreme mental health and social suffering, he discusses the notion of the "non-demand". In fact, I observed that through the privileged relationships sometimes developed, whether they be deliberate or involuntary, the request for help often comes from the service provider whose intervention objective is risk reduction and maintaining stability: *"j'aimerais bien qu'on se voit plus souvent" (John).* Of course, this represents the innate complexity of practice and intervention construction: understanding and observing the paradoxical defense mechanism of the "non-demand", but also navigating the murky waters that flow between an extreme form of social and personal intrusion to ensure outreach and contact, and an extreme form of individual responsibility that places the service user in distress in a passive and isolated space. The negotiation of this, as suggested by Furtos (2007) entails a keen awareness of society and collective issues, but most poignantly of time and space.

7.1.2 Circulating in public spaces

Continuing with the socio-political lens employed in this study, circulation and mobility in the city space are concepts that anchor the contemporary individualized recovery-oriented approach to a more politicized and macro reading of recovery. Whitley and Prince (2005, 2006) discuss circulation as a key element that can aggravate social inequalities experienced by people living with severe or persistent mental health problems. Most community-based services, such as ACT and community organizations in Montreal are strategically located near a metro or bus line. For the individuals who are followed by the ACT team, if they have a medical appointment or another appointment that is not easily accessible by public transportation, a member of the ACT team will typically drive them and accompany them in one of the team's vehicles designated for this purpose[86].

Each individual service user who participated in this project had a chosen circulation in society that bi-directionally impacted their social actions and interactions, particularly with other members of ACT. For example, *Terry* lives in an apartment and benefits from disability payments from his former employer. He visits his mother regularly, volunteers, and takes time from himself. Leisure activities are accessible to him not only because of his geographical

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[86] These are not personal cars but rather owned and managed by the hospital.

location and residential environment quality but also because of his socio-economic situation and his level of integration

> *Ma mère, on est très, très attaché ensemble alors je l'ai suivi partout dans son parcours; à son appartement, à l'hôpital, à un centre d'évaluation et à la résidence où elle est arrivée… L'après-midi, j'essaye d'aller voir un film si c'est possible…J'aime aller dans les restaurants. Avant, j'y allais souvent.*

In stark contrast to this, *Jack*'s circulation consists of riding the metro for at least 2 hours every day. His monthly bus pass is paid using his social assistance payments. He told me that every once in a while he exits the underground and said "*Je marche un peu partout [dans le station de métro]*" before hopping back onto a train. Not only is this part of his daily routine but it is also, according to him, an activity that he considers a hallmark of his integration, recalling the conclusions of Corin (2002) in discussing concerned individuals living simultaneously "within and without" the symbolic limits of society. For *Jack* and for the service providers, he is "*il est bien quand il est capable de faire le tour du sous-terrain*" (*Karl, service provider*). And of course this tour implies leaving the immediate local neighbourhood.

The recent influx of service users living in a situation of homelessness has created some tensions and many discussions with in the ACT team. The perspectives regarding a service user's relationship with his circulation, his community, and his 'homelessness' differ depending on the service user. When discussing *Adrien* at a morning 11 am meeting *Karl* says that he misses living on the streets and sleeping in the metro stations ("*il s'ennui de la rue, de dormir dans le station de métro*"). The team seems to accept this choice but one nurse suggests that this is an indication that he needs to see a psychiatrist. The following week *Karl* discusses this service user at the team meeting with the psychiatrists repeating that *Adrien* wants to be alone and in the streets ("*…il s'ennuie des arbres, du métro, il veut être seule. Il* *se dit reposer et en forme*"). This service user no longer wants a follow up with ACT or to take injections of psychotropic medication. The team deliberates on how they should manage this situation:

> *John*: "*on ne veut pas s'attacher au traitement"*
> *Christine: "on n'a pas de choix avec ce clientèle…*"
> *Derek:* "*son logement n'est pas dans son plan de rétablissement".*

Within a week *Adrien* had returned to his chosen form of living and circulating in the city – in a situation of homelessness. The team accepted this and worked with the local homeless shelter "*si on le voit on l'invite à OBM pour un café pour garder le lien"*. Although the team has accepted that he does not want housing, *Allison* laments "*on a fait des bons coups. Chaque fois que je le voyais je me disais qu'on a sauvé un itinérant"*.

Mike is another service user who wants to return to the streets for the summer. Some service providers are perplexed by this phenomenon of people choosing to return to a homeless life style: "*C'est bizarre qu'il préfère la rue à un logement"* (*Allison*). A few of the team members who worked on the At Home project explain that *Mike* is probably just anxious because living on the street is what he knows and what he is comfortable with. Nevertheless, the service providers insist that he be shown a nearby apartment to rent. They brainstorm ways to have him visit the neighbourhood to entice him to eventually consider the apartment. Finally they agree that *Derek* will take him for lunch near the apartment and *Dean* concurs "*La bouffe, ça marche*". A few months later when subsidized, supervised housing is secured, *Mike* refuses to sleep there regularly. The service providers agree that whenever he does not sleep at the designated supervised housing unit, meaning he is not present for *Med drop*, they will apply the treatment order (the police will be called to take him to the ER to receive his medication). By the end of the month he is complying, no longer sleeping on the streets and

Christine confides to *Robert* in the Great Room "*Mike. Il va bien, il a rentré dans la moule. Il se lave, il nettoie son appartement. La vie est belle*".

The issue of circulation in the community can be thought of as a tension that is continuously being pulled in the direction of normative values and implicit control and also in the direction of person-centred, respectful, engaging process. Although there is limited evidence of mobilization of community partners to renew practice and reduce stigmatization, the disjunctive approaches to participation in a macro sense appear and reappear. It seems to me that this is a difficult tension to cope with for service providers. As one service provider said:

> *La désinformation du public, la peur des gens. Je ne les blâme pas, avant de commencer à travailler en psychiatrie, de voir un sans abris dans la rue qui parlait tout seul, je changeais de trottoir. Aujourd'hui, je suis plus poussé à aller leur parler. Je pense qu'il y a une très grosse désinformation sur la santé mentale. C'est très tabou encore malgré qu'on en parle un peu plus aujourd'hui. Ça je pense que c'est une problématique (Karl)*

Once again themes of helplessness, isolation, and pressure in being an 'end of the line' community based tertiary care program are touched upon.

7.1.3 Social implication and common social projects

Derek informed me one day when we were walking down Ste-Catherine street on our way back from a home visit that the CNESM advised the team against spending time creating support groups or social groups as it is not the direct mandate of ACT. When *Estelle,* a service user, asserts that she would like to do more physical activity (during a semi-annual medication check up with the psychiatrist) her main service provider, *Néomie* suggests they brainstorm ways to combine physical activity with a social gathering. *Estelle* agrees to working with her service provider on starting a sports group. A few days later they meet at the ACT office to plan the group and *Néomie* reports to me that it was a "*rencontre super. On a fait un poster ensemble. [Elle] était très* empowered". The next day I made sure to talk to *Estelle* when she came in to get her money and she reports something different. She said that her service provider "*elle a tout organisé et je n'ai pas dis grand chose*". Although there was a good effort to get a group going, at a community location, it ended up not recruiting enough people. Moreover, *Néomie* stated during an informal discussion in the great hall with *Andrew* that she does not have the time in her schedule to dedicate to organizing it. *Andrew* reflected to her that it is hard to motivate patients and get them out of their routine when there is no obligation. Does this imply that service providers believe that a proverbial carrot is always necessary? Is it a window into the way coercion is understood and accepted? Although coercive interventions and actions were readily acknowledged by service providers when related to the use of legislation and medication, the coercion inherent in control of money, space, and time was less reflected upon and acknowledged by the service providers.

The risk of paternalism in the development of social networks, and of common social projects, is not necessarily one of the types of risks that are measurable or measured by ACT or the CNESM. The implication of service users in common social projects that aim to create social change seems to be hindered by a certain institutionalization of the community. The contradictions are multiple: they speak to the socially unacceptable act of visiting a service user on a day off but the acceptability of the decision to accompany a service user to a soccer game, play video games, or "*magasiner entre les boys*" (*Karl*) when it is within the boundaries of work hours. They speak to the tug of war between developing a social group in collaboration with a service user and investigating the best practices to empower the person to the constraints that the team has to maintain an individualized treatment focus. They speak to the valuable daily, social role that ACT service providers have for many service users, and to the intrusiveness that is the very nature of their work:

> *On peut être envahissant. Ça peut être intrusif pour certaines personnes alors on essaye de trouver des compromis par rapport à ça, mais d'aller chez quelqu'un, recevoir une équipe d'intervenant à notre domicile ça peut être vécu comme quelque chose de difficile et de négatif pour certaines personnes. Des fois, on peut contrôler ça en les voyants ailleurs. (Ruby)*

Accompanying service users in the identification and maintenance of life in the community is an objective expressed regularly by the team. This responds to ACT's overarching fidelity-scale supported objective of hospital avoidance. However, 'life in the community' is understood as an objective measure of housing and life satisfaction in the community as a subjective measure is under examined. The normative expectations of integration through housing, work, or education are prevalent objective measures of success. The aforementioned sense of professional helplessness may stem from a broader acknowledgement of inadequately being able to support service users on a daily basis. Despite the innovative and transformative efforts of the politically active and engaged psychiatrists, the daily lives of many services users remain unchanged due to the structural barriers that exacerbate their marginalized and vulnerable positions in society. For example, when *Charles* said he wanted to move out of his cramped and dark room, he was told that he needed to find employment in order to have enough money to do that.

> *Je leur ai dit que j'étais satisfait à moitié dans ce que je vivais. Dans mon environnement, j'étais satisfait à moitié…La réponse c'est que finalement avec les moyens que j'ai pour vivre…c'est le maximum que je peux avoir (Charles)*

Employment is understood as the principle point of entry for service users to be implicated in the larger social world. The notion of accompaniment, or as *Robert* put it 'doing with a person instead of doing for a person' is somewhat constrained by notions of individual motivation and responsibility.

> *Mes interventions sont basées sur le faire avec. Donc, on est plus dans ce concept de faire pour, on va faire avec la personne. Une des approches c'est la motivation. Supposons que la personne arrête de fumer, il faut qu'on observe la personne, elle est à quelle étape dans sa décision? Avec ça, on va travailler. Au fini, c'est la personne qui prend décision qu'elle veut aller travailler. Mais nous, notre rôle ce n'est pas de lui dire va travailler. C'est de susciter chez la personne le besoin d'aller travailler. Ou de susciter chez la personne l'utilité d'aller travailler ou l'avantage que le travail aura sur ton rétablissement, c'est-à-dire la gestion. Le but : apprendre à vivre avec la maladie. Comment est-ce que je peux gérer mes symptômes? Une des manières, c'est de travailler. (Robert)*

The social worker in charge of the Individualized Placement Service, *Dean*, was tasked to assist *Charles* in finding employement *"pour qu'il puisse s'en sortir"*. However, the lack of appropriate job offers, the constraints imposed by government programs on subsidized employment possibilities and the stigma associated with an ACT follow up and an empty c.v. are not easily overcome according to *Dean*. Engagement with society at a street level remains inconsistent. Within the framework of psychiatric services and care however, to me this seems to be a strength of this urban ACT team that is struggling to break free of the normative definitions of ACT and incorporate their knowledge and the lived reality of service users (homelessness, substance use, social isolation, extreme socioeconomic inequalities) into the very fabric of their service offer.

However, as the IPS specialist, other team members tend to defer to him when questions of integration are raised. In addition to this silo effect, he says that he feels pressure from the *Ministère d'emploi et de la solidarité social* to get people off of social assistance and into full time employment; the possibility of social integration through volunteer work is not clear cut and is hampered by the pressures to relieve the social assistance program. The IPS program is an evidence-based work placement program – unlike in other organizations in Montréal, service users in ACT have access to the program without a formal medical referral. Although returning to work is a major objective not just of the ACT program, but of broader social integration orientations in policy, *Dean* expresses concerns about the current workplace:

> *Le travail est tellement une source de stress. Pour eux c'est tellement irréaliste. Quand une personne commence IPS, lâche, il ne faut pas perdre de l'espoir. C'est correct. Il ne faut pas lâcher prise…je mets beaucoup de personnes en formation qui n'était pas sanction par le programme comme tel…j'ai participé à une téléconférence aux États-Unis et j'ai dit ça. Maintenant c'est considéré comme important"*

Whilst training or education have become part of vocational support, the timing of these interventions is often based on the premise that the service user is unmotivated, or needs a carrot in order to want to participate. For example, *Dean* explained that he would delay a job search with *Nathan* until the middle of the month because he just received his social assistance cheque and won't be motivated to look for a job.

Resistance to interventions is often handled through coercion and individualized blaming:

> *Elle est sur curatelle, on a un levier avec elle* (*Néomie*)

> *Mais ce n'est pas par rapport à nous qu'ils ne sont pas disponibles, c'est eux qui ne sont pas très prêts, je ne sais pas, peut-être qu'ils ne sont pas capables de faire ce genre de choses là mais on essayé pas mal (Allison)*

Although sometimes it is managed by exploring individual motivations through a phenomenological approach to questioning the meaning a person might prescribe to work, hygiene, or safety. *Robert* articulates well the source of professional hopelessness and explains some of his strategies to manage this:

> *Peut-être que de trouver du travail ça ne marche pas avec cette personne là. Alors on va aller voir s'il a d'autres intérêts, autre que le travail parce que le but final ce n'est pas de travailler, le but final c'est le bien-être de la personne, de se sentir comme un citoyen à part entière. Il y a des citoyens qui ne travaillent pas mais qui sont biens. Donc le but final c'est le bien-être de la personne. Peut-être qu'à la place, aller s'entrainer ou aller voir sa famille… Dans le passé, qu'est-ce qu'il l'avait rendu heureux finalement? Donc il faut voir qu'est-ce qu'il a besoin finalement? Quels sont ces intérêts? Parce que souvent, il y a des impasses surtout avec le monde qui ont des maladies vraiment sévères. Il y a plus d'échec que de réussites. Donc c'est là où ça devient des fois un peu lourd pour l'intervenant, de se remettre continuellement en question, de créer ces changements, de créer un cheminement, un milieu, un environnement favorable pour que la personne elle-même puisse choisir. Si on choisit pour la personne, à 99% c'est un échec. Je donne un exemple où on force les patients à aller en désintox. Des fois, en tant qu'intervenant, on sait que ça va être un échec mais on le fait parce que parfois il n'y a plus d'autres solutions possibles. Personnellement, je sais que ça ne va pas forcément marcher, mais des fois on n'a pas d'autres solutions. Des fois, on se dit que la personne va dégriser un peu et que peut-être qu'il va y avoir une étincelle qui va naitre à partir de là pour qu'il se sente mieux. On espère en faisant ça que peut-être que ça va susciter quelque chose dans la personne parce que le rétablissement si ça ne vient pas de la personne, si la personne ne se dit pas un jour : Ouf, peut-être que je dois faire autrement finalement… Donc il se peut que les médicaments t'aident. Quand on le dit souvent ça n'a pas d'effets et on est plus découragés, on est humain. En conclusion, on espère que tout ce qu'on a fait en tant qu'intervention ça marche. Pour que la personne se dise : ok, maintenant il faut que je me prenne en main.*

This interview extract is particularly poignant in that it speaks to the potential for an organizational culture that has an expanded and progressive perspective of the individual that is strengths-based and respectful. It also hints at the recognition of a broader definition of integration and inclusion that is focused on the service user's well-being and that is unconstrained by normative expectations such as employment. Finally, it is enlightening to explicitly know that the source of *Robert's* very human and natural fears, anxieties and pressures is a preoccupation for the service user's well-being rather than a preoccupation for administrative procedures and symptom reduction.

If a building has unsafe stairs, or requires winter snow shovelling, then minimum safety standards will be assured by the team and they will contact the landlords directly. For example, *Melanie* is very upset with her housing situation as there are cockroaches in her apartment. This is discussed at a team meeting and one of the social workers comments that many of the available or affordable housing in their territory has significant problems in terms of hygiene and safety. However, the discussion point does not leave the table, lead to other discussions, or translate into action. The team speaks specifically about *Melanie* stating that *"Elle n'a pas de matelas juste 2 tables donc elle couche chez ses amis à Montréal Nord"* and *"Elle a pris l'appartement pour nous faire plaisir".* Nevertheless, the *Med drop* is not happening because she is often not at her apartment. The team gives her a strict time window to be present at the apartment for *Med drop*, otherwise they agree that they will request a treatment order in order to legally oblige her to be present under threat of police escort to the ER for medication.

It seems that the term 'community' for the ACT team refers only to housing outside of the hospital. The paradox of this 'community' is in the risk of institutionalizing independent, community based housing. For example, given the limited availability of affordable housing, the team has successfully developed a network of landlords with whom they regularly liaise and refer service users. Thus there are some buildings in which every small room or apartment is occupied by an ACT service user. Or in some cases 3-4 service users will live at the same building. This facilitates *Med drops*, and at least once a day there is an ACT service provider visiting all or some of the occupants of the building. Thus, the displacement of the psychiatric hospital into the community may result in the professionalization of individual needs such as a social network, meaningful activities, stable housing, spirituality, and self-development. Has this become an asylum in the community, or is it, as one service provider explained during the interview, that this is the type of 'ghettoized' housing that service users prefer because it creates opportunities to socialize among peers?

7.2. Life of quality: are hope, time, and community living enough?

In the ACT structure, every interaction between service providers and service users is filtered through the very different social positions that they hold. This inequality is most often discussed in the literature related to the professional-patient dyad, but the imbalance is exacerbated by the complexity of social problems and social inequalities faced by the service users in this ACT team. In the interviews, service users named their difficulties as loneliness, suicidal thoughts, lack of income, drug use, housing insecurity, lack of access to leisure activities such as a gym or a library. Service providers for the most part mentioned social isolation and poverty as the principal socio-economic problems faced by the population they serve. They almost all recognize the complexity of the problems faced by service users, and the difficulty they have in adequately responding to these problems. Again, a feeling of professional hopelessness is suggested. However, let us return to the idea that small gestures and small acts of kindness can have a big impact on a person and start to create spaces for potentially transformative conversations (Bourgeois, 2006).

7.2.1 Hope and time

In terms of improving a life of quality for service users there is a sense of excitement and hope from service providers that seems to counter balance the sense of professional helplessness that comes with being an ‘end of the line’ service. Service providers resist the feelings of helplessness and manage the pressure the have to maintain service users in community housing by reminding themselves that ACT offers two intangible elements that are unique in tertiary psychiatric care. Both of these elements, hope and time, are tied to the flexibility in the organizational structure and the flexibility in the teams room to manoeuvre.

> *C’est drôle comment les gens acheminent avec le temps. Le [suivi intensif] c’est le temps (Christine)*

> *C’est une des grosses particularités du Suivi dans le fond, de prendre le temps d’essayer des affaires avec eux. (Sue)*

The particularity of the service providers that compose the ACT team is their continued hope, built through professional respect and through an awareness, if not necessarily always the capacity, to intervene in different ways than what is typically sanctioned in psychiatry and in our overarching results-based health and social service sector.

> *On a vraiment un ensemble de perspective et de possibilité. C’est un milieu qui est très effervescent je crois (Derek)*

The service provider who deals almost exclusively with the Individualised Placement Program explained that his passion for his work is based in his strong belief that it will provide hope for the service users and for himself as a professional:

> *C’est tout ça qui amène ces gens là à être comme ça. Ils perdent leur emploi, leur santé, ce n’est pas facile. Alors nous on est là pour recoller avec eux les morceaux du puzzle. Ça ne veut pas dire que cette personne est hypothéquée et que c’est fini.*

> *Je pense qu'il y a aussi de l'espoir. Le fait de travailler, l'emploi est une façon de les réinsérer socialement. L'emploi c'est aussi l'espoir. (Dean)*

The different ways of engaging in relationships in close proximity make up the specificity of ACT interaction and are often referred to by the service providers as 'accompaniment'. These actions and interactions are not framed by clinical tools or clinical guides and are often context and person dependant. They can range from feeding a service user's cat when they are hospitalized, to helping them move apartments, to buying groceries and cooking supper together. For service users, the hope and time that is offered through the structure of the ACT team is important for their recovery process specifically as it relates to social relationships.

> *Le [docteur] est venu chez moi, il était là lui avec deux autres personnes qui travaillaient ici pour m'apporter son soutien, sa tendresse et son amour. Il n'était pas là comme un médecin ou un psychiatre, il était là comme un être humain (Terry)*

> *Ils viennent me voir, voir comment ça va, si je suis correcte, si mon moral est bon, si je mange bien, si je prends bien la médication…Disons que c'est un soutien finalement. C'est la raison de l'appartenance finalement. C'est une équipe qui s'occupe de moi. Moi ça me satisfait finalement (Chris)*

> *J'ai pas de famille et c'est l'fun qu'ils y a des gens qui ont de l'espoir en moi (Estelle)*

Services providers discussed in the interviews elements of a successful intervention. Often this was expressed as the service user having "collaborated" or having established "good objectives". This service provider (*Sue*) explained that an interaction is successful when she has the feeling that she has helped the person:

> *C'est souvent quand tu sens qu'il y a quelque chose qui est aidant. Tu sens que par la présence ou par la discussion, la personne en retire quelque chose de bénéfique ou de positif*

A failed intervention, in contrast was defined as one in which a relationship, or alliance, with the person was not possible. The fault for this lack of connection, in the following citation, is attributed to the service user

> *Une intervention quand c'est un échec, c'est plus quand les gens ne sont pas réceptifs. C'est beaucoup quand ils sont désorganisés et quand il y a de la consommation, quand ils sont super agressif…ça rend l'intervention très limitée (Sue)*

I have already discussed the reticence with which service providers engage in a central aspect of their job – medication compliance. In light of this constraint, it is relevant to return to relationship building as it is justified through the impetus to avoid hospitalizations.

7.2.2. Developing a therapeutic alliance

> *C'est des principes d'intervention…notre principe d'élaborer une relation thérapeutique qui soit en fait un espace où la personne peut verbaliser ou elle peut élaborer les choses pour travailler sur son rétablissement. Le principe de l'intervention c'est de créer un espace de médiation où on va aider la personne à métaboliser un petit peu des choses qui se passent et l'aider à élaborer et avancer là-dedans. Le principe, même si c'est juste pour un Med drop, c'est de créer cet espace finalement. (Andrew)*

Hope and time exist in the practice of the ACT program as evidenced by *Nathan's (service user)* assertion that *"L'espoir c'est comme être bien pour que ça aille mieux*". So how are hope and time transmitted to service users? How are they unearthed in daily actions and interactions? Early on in the field work data collection process, I had a frank discussion with the team lead. She talked about creating a strong therapeutic alliance as a central component to a non-invasive, negotiated intervention. She gave an example of a service user with whom she has a strong relationship of trust. One day she went to his home and he told her he wanted to go to the police station immediately and have them test his medication because he thought they were poisoned. She agreed to accompany him but he made her walk several paces in front of him. She felt like she was a hostage but also trusted the relationship she had with him and most importantly did not fear his madness. At the police station she spent hours negotiating with the patient and with the police until he finally agreed for *Urgence Santé* to be called. She says that as a service provider her objective was for the service user to go to the ER without police accompaniment and without handcuffs and she succeeded.

Another service provider, *Karl,* explained his good relationship with *Estelle*. When I was observing them one day as she came into the office to get her medication, I watched her take it in front of him. Then they spoke briefly about sewing, an activity she seems to enjoy. *Karl* explained to me afterward that she likes to talk about non-utilitarian things and that she responds well to humour. He explained that because he is a gregarious person who easily tells jokes, he has succeeded in developing a solid therapeutic alliance with her. “She trusts me”, he says. And he seems to sincerely enjoy his interactions with her, making sure that he is the service provider to greet her at the office if he is available. At a team meeting another service provider discussed this service user and says

> *My relationship with [Estelle] is going very well. We have a lot of fun together (Néomie)*

In turn, when I asked her about her relationship with the service providers this service user reciprocated the sentiments stating:

> *[Venir ici] ca donne une présence humaine aussi. Tu arrives ici et le monde est de bonne humeur, tu vois du monde. (Estelle)*

Therapeutic alliance implies getting to know a person for who they are, their interests, their life story, and thus going beyond a reductionist description of symptoms. One service provider explained the centrality of the therapeutic alliance:

> *Un lien. Quand on a un lien avec un client, on a tout. Le reste c'est du bonbon. Un lien de confiance, un lien humain (Dean)*

It is not surprising that service providers' subjective experiences taint their affiliation and affinity toward certain service users. This is evidenced in frequent side comments such as "*il est mon préfère de ce temps ci".* The ACT team, through their frequent contacts with the service users, and for the most part, because of the sincere interest from the service providers, has succeeded in initiating a trust relationship with most participants. This also serves to understand, respect and recognize a person's fears or concerns. For example, when *Liz* was transferred to a residential and rehabilitation unit at another mental health institution she was nervous and suspicious of the change. Her main service provider, *Sue* and the team agreed to visit her there twice a week "*pour la sécurisé"* and the psychiatrist suggested giving her extra money from her account that they manage. Other service users discussed the new sense of security they feel in having a safety net.

This person is experiencing complex social problems such as isolation, poverty, substance use, and gambling. He says:

> *…Je viens ici quatre fois par semaine. Alors quatre fois par semaine je viens ici, ça ne dure pas longtemps mais j'aime ça quand même. Ça me fait sortir…et si jamais j'ai un problème, je sais qu'il y a quelqu'un ici qui peut m'aider. » (Nathan)*

This person lived on the streets for many years, had a traumatic experience with bed bugs, and is focused on maintain clean, adequate housing. He says:

> *Donc si on ne nous aidait pas, peut-être qu'on aurait des problèmes au niveau du logement. Sauf que là on est organisé, on sait où on s'en va. Moi je suis géré par le CHUM, mon argent est géré par le CHUM St-Luc. C'est eux-autres qui gèrent mon budget. J'ai un budget à tous les mois. Le loyer est payé par le Suivi intensif à partir de l'hôpital St-Luc. (Charles)*

As per my methodological notes I think service users agreed to participate in this research because they have a strong trust and therapeutic alliance with the service providers who are helping recruit and who are also truly interested in the project.

In the ACT team every action and interaction is part of a hybrid service culture that is on the one hand person-centred and flexible and on the other hand symptom focused and coercive. Once a strong therapeutic alliance has been created in a professional-patient dyad, and in the ACT team it is often on the premise of developing a social relationship, then the line between a paternalistic interaction and one that is egalitarian and potentially collaborative is blurred. For example, one of the psychoeducators, *Derek* discusses another service user who is refusing medication. He says that he feels his intervention was successful because he has a good relationship with her. He was able to "confront" her and "persuade" her by telling her *"ta jeunesse s'envol et les médicaments peuvent vous aider*". In another example, the team was discussing a service user who sits in his apartment, immobile, for hours at a time because he does not want to bother the ghosts walking around his apartment. *Derek* suggests that the team co-construct a solution with this service user by asking him how he feels the ghosts could be eradicated. The team, however, decides it would be faster – despite the time inherent in the ACT follow up - to tell the service user that they called an expert themselves and that this ghost expert advised them to use burning sage as the best way to remove ghosts. They then agreed to buy the sage and have a "séance" with the service user. Sometimes, as mentioned above, 'the person is forgotten' in the production of interventions. For example, when the landlord of a hospitalized service user (long term hospitalization) said that his rent was not paid and that he would move out, one of the service providers arranged for a moving company to donate the service user's belongings to Goodwill without telling him. It is one of the few times when I felt the professional responsibility to intervene, and I suggested to this service provider that he discuss the decision with the team lead. When the team lead heard about this plan she immediately stopped it, citing the importance of respecting the person and his belongings.

The relationship that can be built with in an ACT team due to the time and hope that is offered by the service is certainly very real and almost ideal. However, the relationships, which are embedded in a professionalism that maintains strict boundaries, do not erase power inequalities and the specificity of the belonging to a certain group (service user, professional, psychiatrist). This division is a major challenge for the ACT team as they work towards improving the quality of life, and supporting a life of quality, for service users in the community.

Once again structural constraints, as well as professional constraints, seem to be a major limiting force in term of creating transformative change. One service provider dared not even use the word transformative in the interview, and when I asked three times if he thinks there is potential for ACT to intervene in a way that would lead to personal or social transformations he insisted that ACT is only responsible for "*Beaucoup d'amélioration, je préfère ce mot"* (*Dean*). It seems that this is partially due to the perspective related to the problems that service users face and to the use of observable, symptomatic descriptions of socio-economic inequalities such as lack of housing, unhealthy accommodations, substance use.

> *Beaucoup de questions de logement, beaucoup d'enjeux de consommations, tout ce qui entoure l'argent c'est aussi des fois assez problématiques avec nos usagers. Justement, quand il y a de la consommation, des fois c'est difficile de respecter leur budget, ils veulent toujours plus. Logement, consommation, argent, ça tourne beaucoup autour de ça. (Sue)*

Since the problem is defined by naming the symptoms of a deeper issue, only the symptoms of poverty and inequality are managed through normative interventions focused on housing, employment, and education. The other constraints that might be limiting the engagement of ACT in more transformative changes with service users and in their community life is the perspective service providers have of their own practice limits. Service providers generally concurred that they focus on the observable mental health difficulties while other teams, groups, or services will work in partnership with them to manage and support in other aspects of the person's life.

> *Nous on est là pour la santé mentale mais il y a toute l'équipe de soins qui est là dans la résidence pour elle. Des fois c'est arrivé qu'on les rencontre, qu'on leur parle de la santé mentale pour qu'ils comprennent un peu qu'est-ce qu'elle peut vivre. Ce genre de choses là, mais dépendamment du milieu où elle est… (Sue)*

The mandate of ACT teams is to work in the community. However, the distinction between community -focused care and community-based care is not necessarily explicit. As previously mentioned, community-focused care includes promoting the development of citizenship roles and connection with social roles in the community; finding meaning and purpose in life; working to fight stigma and increase access to a variety of resources, and developing a positive culture of healing (Stein, 1989 in Davidson et al., 2009). The accompaniment and community care offered at ACT often falls into the community located category. For example, it might include visiting a service user at home and then going to a residential care unit at a psychiatric hospital to complete an intervention plan; or accompanying a service user clothes shopping; or accompanying a service user to her visit with youth protection workers. When too many people are hospitalized at once the team reflects and denounces their often knee-jerk inclination to hospitalize them simply because it's the easy option ("*c'est l'option facile*"). This is reinforced by one of the psychiatrists who reminds the team that avoiding hospitalizations is their objective:

> *"[Éviter les hospitalisations] c'est le but de notre équipe. Chaque hospitalisation est un échec, pas un moyen*" (*John*).

The difficulty inherent in the service offer is in finding or creating alternatives to hospitalization. This may be due to the practice approach of risk reduction and the feeling of professional insecurity that comes with being an 'end of the line' service.

In short, in 2014 within this urban ACT team, the question of participative, service-user oriented practices in psychiatry is already being debated. This debate can be understood as situating this particular ACT team as not only a physical space where community mental health work is accomplished, but also a social and political space wherein madness is woven into the fabric of the community and of society. This latter occupation unearths many of the constraints and questions regarding the relationship this psychiatric team has with the idea of madness and with the realities experienced by service users. The description of recovery and recovery-oriented perspective within this urban Montreal ACT team unveils an organizational structure that is opening the space for potentially creative and participative actions and interactions amongst actors – that is to say, interventions that seek out and sustain the participation of service users in their treatment and in their lives in the community. Perhaps paradoxically, this same structure is governed by traditional practices and neoliberal policies that maintain and support traditional professional-patient relationships and cost efficient treatments. Moreover, the position of this elite team within the psychiatric care structure might even legitimize the use of more coercive practices.

Chapter 8 – Discussion and conclusion

The present study used an open, interpretive, critical methodology to explore the construction or co-construction of mental health interventions through the observation of daily, routine, common sense decisions, interactions, and even invisible work that may facilitate or hinder a recovery-oriented practice approach. Data from participant observation, documentation, and literature reviews were my main source of information, supported by interview findings. The data revealed differences and similarities in discourses and actions in the ACT team, which expose the current paradoxical juxtaposition of community-based approaches in a program that remains imprinted by traditional norms and influenced by individualizing managerial priorities. This study has explicated the reasons and motivations for developing certain types interventions and the role and impact of interventions on both service users and service providers. The study also sought to understand the experience of receiving services from a mental health team and more provocatively the willingness of service providers and service users to develop concrete mechanisms in order to foster spaces for reflection and negotiation. The study sought to answer three questions, specifically:

1. How is recovery-oriented practice accomplished?
2. What does recovery mean to both service users and service providers in community mental health practice?
3. Do ACT teams have an organizing principle that helps service users take on a citizenship role that empowers them to co-create supportive communities within the service and in the community?

8.1 Responding to the research questions

The findings[87], presented in Chapters 5, 6, and 7 present the structuring role of the organizational framework, legal tools, and current policies in use that influence the accomplishment of interventions. They also analyze the specificity of this ACT team through the actions and interactions that are linked to participation, community mobilization and engagement, and flexibility. The findings also highlight many invisible 'wins' and positive practices that this urban ACT team is achieving. Finally, the findings explicate the significance and implementation of recovery practices, which are variable not by way of individualized interventions, but rather by way of service provider expectations of certain groups of service users having the potential to recover. In addition to re-articulating the strengths of the team and the embryonic potential for innovative and transformative practice, I will also respond directly to the broad three research questions.

8.1.1 How is recovery-oriented practice accomplished?

This study found that recovery-oriented practice is accomplished through a form of institutional accompaniment that is developed based on both a singular, intimate knowledge of each service user, but also through a negotiation of outcomes for groups of service users.

Service providers believe in the general idea of recovery as per my observations and the interviews, but the construction of recovery-oriented practice is more elusive. There are paradoxes and complexities specifically related to institutional accompaniment. In this ACT program, embedded in a rigid institutional structure, Karsz's (2004) notion of accompaniment, understood as attending to an individual's particular journey with that person (Karsz, 2004;

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[87] The everyday world of this urban ACT team is dynamic and in action. My findings are embedded in this dynamic active state.

René, et coll., 2010; RRASMQ, 2009), is less present. The institution offers a more traditional role of providing a safety net for service users. The discourse of accompaniment is prevalent amongst service providers, however, the actions and the sense given to 'institutional accompaniment' differ significantly from the actions and sense given to accompaniment that emerged from the alternative mental health movement in Québec. This ACT team seems to accomplish a hybrid type of accompaniment, in which some service users are externally evaluated as being on a 'maintenance' track and others on 'recovery' track. Interventions and relationships are constructed in consequence of the outcome that is *apriori* determined for the service users. Both 'tracks' include interventions that aspire to positively affect the service user's social environment (housing, social network, hygiene) and have a symbolic value associated with wellbeing, recognition, solidarity, and participation. However, the development of proxy social networks and institutional housing in the community without a transformative agenda may serve to legitimize the social position and power imbalance of one group (Godbout, 1993 in Pelchat, 2010). Moreover, the two tracks in this institutional accompaniment are embedded in the role that ACT plays as a proxy, uni-directional social network for most service users. The development of a proxy social network might be stimulated by the social skills training offered by ACT; it might also be reassuring and structuring for service users who require and desire that. But, there is a risk that it becomes a mechanism for 'social contention' and limits effective development of sustainable and reciprocal social connections and social cohesion.

Conceptions of service users

This research offered an opportunity to identify the ways in which service users, and their lived experiences, are understood and conceived of by service providers. Specifically, this research demonstrated that the challenges of institutional accompaniment lie in the conception of the service user in relation to her mental health difficulties. My findings indicate that the interactions between service providers and service users, and the subsequent conceptualization of the service user and the interpretation of varying situations, continue to be entrenched in a paternalistic and patriarchal approach. The examples offered in the previous chapters may indicate that this conceptualization is often one in which the individual is ultimately responsible for her recovery and well-being, yet simultaneously lacks the ability to fulfill that responsibility. This predominant reductionist conception is one that lends a hand to understanding human behaviours and motivations as rational and logical actions rather than as complex and contextualized interactions and actions. As such, it is not surprising that the contexts and basis for suffering and distress are often unexplored, while the superficial symptoms, which are in and of themselves distressing and a source of suffering, are the common points on which service providers engage their interventions. The ease with which symptoms of distress are recognized, quantified, and shared with the team makes them obvious spaces on which to provide a 'successful' intervention, and are perhaps a reason why practices remain medically focused. However, the subjective, unique, and complex processes remain largely unexplored in the framework of institutional accompaniment.

Nevertheless, the study findings show that several service providers offer less medicalized and less paternalistic perspectives than expected. Their interventions[88] seem to be the result of an evolving interpretation, or conceptualization, of 'the mental health service user' and of specific situations. It is vital to underscore how representations of a situation or a

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[88] For example, when *Christine* noted that it is not appropriate to empty out a service user's apartment without, at a minimum, his knoweldge or when supervisory interventions assisted *Karl* in developing a different perspective and approach to a service user in distress who was calling him several times a day.

person can potentially change practice; perhaps the quality of the interpretation of situations and people can actually transform the potential of the human relationship between service providers and service users and practice interventions.

Conceptions of medico-legal and administrative tools

Another significant challenge to the accomplishment of recovery-oriented practice that this research unearthed is the ready use of legal and administrative tools and the leveraging of resources that ultimately result in coercive practice. This study confirms that the ACT objectives of avoiding hospitalization and maintaining community housing are so entrenched and predominant that interventions are focused on risk and harm reduction, maintaining 'normalcy', and symptoms reduction. In order to accomplish the outcomes associated with those interventions, negotiations with service users readily enter into the spectrum of coercion. This might be through the threat of applying a treatment order or through using money and social privileges as leverage. These apparent coercive interactions are not seen by the ACT team as exploitation because their ultimate purpose is to respond to the objective of the program, that being hospital avoidance.

Moreover, there is a specific paternalism that has developed wherein the team is very protective, and perhaps even overbearing, of service users. This may be due to the role of the ACT team as the principal point of socialization. If there is a risk that a service user will be exploited by a landlord, telephone company, employment institution, or their friends, the team is quick to step in in order to accomplish the task of negotiation or interaction with society, on behalf of the service user. The use of these procedures, tools, and processes dominate the construction of practice and are a central component to the institutional accompaniment observed during the course of this study. These procedures and tools are perhaps readily validated because they are coherent with the managerial paradigm governing organizational health structures. However, the findings of this study illustrate how service providers, often faced with complex and anxiety-provoking situations regularly rely on the safety and security of these tools in order to enforce their objective of risk reduction and decrease complexity and unpredictability in their practice.

The findings of this study suggest that the balance between offering accompaniment and providing a social safety net articulate the new frontiers for psychiatric community mental health care. Accompaniment doesn't typically enter into the habitual forms of support and assistance in institutional practice. My findings indicate that intensive community-based follow up, or institutional accompaniment such as the ACT team, manifests itself primarily through the development of a uni-directional institutional social network and the development of institutional housing in the community. Each manifestation of institutional accompaniment possess paradoxes and challenges as well as surprising, invisible gestures that offer hope and potential for a renewal of recovery-oriented practice. The findings outlined in the previous chapters offer many examples of 'open doors', both in action and in discourse, that demonstrate the potential and possibility for innovative, emerging practice at the institutional level. These 'open doors', which are often entrenched in a humanistic, non-medicalized interpretation and representation of service users and situations, offer new ways of understanding how practice can be co-constructed. Service users themselves indicated that although it is important, even vital, for them to avoid re-traumatisation through hospitalization, a life of quality in the community requires more than a change of location of care from hospital to apartment. From the perspective of participating service users, this research helps explore the limits and possibilities in community mental health practice.

The strengths of this ACT team

As aforementioned, both institutional accompaniment and the very attempt to integrate a recovery concept at the practice level are significant in that they are perhaps a first step to fertilizing the ground for the idea of transformation, for a more inclusive recovery framework, and for starting an open dialogue with service users.

To begin, this urban ACT team demonstrates a strong camaraderie and successful creation of a safe space for professionals to share and learn from each other. They have fostered a team culture that is respectful and conscientious of their interactions amongst themselves and with service users. There is sensitivity to the power and control that their tools and professional status invoke; their professional malaise with coercive practices and the surveillance and control of service users is bubbling at the surface. Moreover, the engaged and active team lead and psychiatrist confront the imprint of traditional psychiatric practices and of the influence of top-down managerial structures. They do this through close consideration of their practice context and by offering a broader perspective of the potential impact that they can have. Although social inequalities, poverty, and social precarity are not directly impacted with current interventions, the members of this team are creating fertile ground for expanded practices and interventions that consider these structural barriers to well-being and inclusion. For example, the team expanded their inclusion criteria, and as *Christine* and *John* (both service providers) told me, they have integrated interventions and practices to respond to complex needs such as homelessness, and to respond to mental health problems typically excluded from ACT such as personality disorders and psychosis secondary to chronic physical health problems.

The 'invisible wins' that I have documented also include small, yet significant gestures that are anchored in potential access to each service user's singularity. Here I am not referring to a successful integration into work or school, but rather to the use of the ACT space and place to develop a genuine connection and relationship with a service user. I am referring to moments when service providers brought in an old pair of running shoes in good condition for *Nathan* who was otherwise walking around the city with broken shoes in the winter; when *Angus* (service provider) went out for a hot dog with *Adrien* (service user) after which *Adrien* proclaimed that next time he would pay for both their hot dogs; when, with the permission of a hospitalized service user, the team carefully packed up his belongings and placed them in a storage unit for safe keeping; when *Andrew* (service provider) was accepting of and showed interest in *Joel's* (service user) pet rat; when *Christine* (service provider) took a sincere interest in *Chris's* (service user) work as an author and dialogued with him about his ideas for social housing. I am also referring to the successful development of a service that expands the boundaries of psychiatric practice into street psychiatry

8.1.2 What does recovery mean to both service users and service providers in community mental health practice?

By exploring mental health practice and broader systemic constraints on practice such as performance outcome measures and rigid organizational structures the findings from this research suggest that recovery-oriented practice is understood as an individualized and medicalized orientation. The findings of this study demonstrate that recovery is understood by both service users and service providers to be an individual, autonomous process and goal. However, due to the complexity of problems faced by service users and the conceptualization of the service user as described above, it seems that expectations for service users to actually be able to recovery, make connections with the community, and become independent of the ACT program are very low. The mechanisms used to promote recovery and recovery-oriented practice are significant to participants in a strictly operational and individualized manner so that the construction of practice does not confront structural issues. Thus current recovery-oriented understandings and actions and interactions don't necessarily lead to an increase in equality, social justice, destigmatization, and social inclusion, but rather lead to individual service users finding their voice within individual interactions at the micro-clinical level.

This research demonstrates the significance of mental health recovery for adult service users who have said that recovery for them means peace, or balance, or staying out of the hospital, or having friends, or living in safe housing. One service user, who lives in a boarding house, told me that he is in recovery because he no longer lives with bed bugs. Another told me that she is not in recovery although she is in secure housing and has reconnected with her father, because she feels existentially unaccomplished. Others have questioned whether or not they even want to be in recovery, feeling that it is an obligatory path imposed on by their service provider.

This study has also explicated what recovery-oriented practice might be for mental health service providers: a previous study showed that most social workers in a primary care mental health team felt that recovery was something they had always done because it is aligned with social work values (Khoury & Rodriguez, 2015). In this present study, findings indicate that service providers understand their role as helping individuals and groups live as normally as possible by accompanying them in job searches or in connecting with others. Across the board, service providers reported that in their practice they were unable to get their interactions to line up with how they felt they should or could intervene, particularly with respect to stigma and structural barriers such as inadequate housing or poverty, mostly due to administrative pressure or organizational constraints.

The juxtaposition of recovery on a relatively rigid organizational structure means that its significance, within the ACT program, no longer refutes the biomedical perspective of chronicity in mental illness nor does it explicitly acknowledge the social factors that contribute to mental health difficulties. Thus, mental health practice can be understood as a paradoxical endeavour wherein well-intentioned service providers report feeling restricted in their intervention choices. Service providers indicated that they feel helpless and hopeless in tackling the entrenched problems of the people with whom they work. Most believe that both recovery and recovery-oriented practice are tied to a normative view of social integration (that is restricted to employment, housing, and education), which cannot be accomplished by service users without professional support. Ironically, this is juxtaposed on the aforementioned understanding of recovery as an autonomous endeavour wherein participants in this study conceive of recovery-oriented practice primarily as an individualized support.

8.1.3 Do ACT teams have an organizing principle that helps service users take on a citizenship role that empowers them to co-create supportive communities within the service and in the community?

Finally, my findings indicate that social inequalities tend to be considered as relevant, but distant, unexamined background noise in current organizational and professional structures. The priorities in terms of the construction of interventions that are innovative revolve around providing treatment, housing, and vocational and social support. The participating psychiatrists are engaged and active in practice and policy and have been instrumental in securing increased funding to services for the homeless population as well as advocating for street psychiatry in which they and the other mental health service providers meet service users not just in their homes but on the street corners if necessary. My observations indicate that their focus is on outreach and providing care; this focus has the potential for both self-transformation and larger social transformation.

Notwithstanding, neither the traditional psychiatric model of chronicity and pharmacologically centred interventions nor the managerial paradigm of outcome measures and cost efficiency is questioned by the institution and the actors involved in this study, but rather it is normalized and integrated into a reconceptualized and diluted understanding of recovery. Thus, it seems that this community mental health team preserves the social order of traditional, individualistic psychiatry, wherein use of laws and tools and intervention norms are developed that mostly maintain a reductionist biomedical status quo, rather than transform or change it. What emerges from the results chapters and what I have observed is that the position of an intensive community mental health team such as ACT does influence many external actors in the community. I can think of the positive destigmatization work the service providers engage in with police officers, pharmacists, landlords, and coffee shop owners. However, the discussion and action are curtailed by an emphasis on individuals. Can we talk about community and community mental health treatment whilst remaining focused on the individual?

If the reader considers once again the examples of the service user who wanted to start a sports group in order to socialize and workout, or the service user who suggested that ACT could support a push for more social housing, she may begin to think about what kinds of communities might be created through an attention to both the singular citizenship role of service users and the potential in co-creating supportive community spaces. This might offer a new perspective on practice and interactions. Future research related to community network mapping could provide further insights.[89]

In sum, a larger social transformation that would co-create supportive communities is not evidenced at this time likely due to the 'recovery-oriented' actions taking place in a space that is highly individualized with few structural and collaborative considerations.

8.2 Implications

The conceptual frameworks for practice therefore need to be revisited in order to further understand the practice dynamics in an urban ACT team and how it can be made more recovery-oriented. The ACT program framework, using intensive, assertive, and persistent outreach and a specialized case management model, suggests that recovery-oriented approaches are achieved through fidelity to Wellness Recovery Action Plans and the use of Illness Management and Recovery training manuals. It is however noted from this study that the operationalization of recovery through these modes is actually accomplished via an understanding of recovery using the internal schema presented in the previous chapter, developed by one of the psychiatrists. Moreover, the naming of recovery in policy and in a schema does not necessarily offer a mechanism or pathway towards actions and interactions that are indeed recovery-oriented. In other words, the usage of the word recovery is not particularly useful if the concept of illness, madness, or mental health is not transforming. The individualistic conception of recovery that is endorsed by policy, psychiatric institutions, and

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[89] This will be briefly discussed in the concluding remarks

even practice frameworks such as case management is conceptually narrow and theoretically limited. Thus, it limits the actions and interactions that would lead to the co-construction of interventions that sustainably transform service users' lives.

The most recent Québec Mental Health Action Plan has extended the theoretical underpinnings of recovery practice to include ideas of citizenship at the intersection of a recovery process. However, the present study seems to point to the fact that community-based mental health care programs have still not integrated the complexities of community-focused practice rather than community-based practice. Although the location of practice has shifted from the asylum to the streets, the fundamental underpinnings of practice approaches have not transformed enough to respond to the original, emancipatory, social justice crux of the recovery perspective. This research has used empirical findings to show that past and current recovery-oriented policy initiatives in the MHAP are not making the anticipated impact due to challenges in the juxtaposition of recovery with managerial and hospital-centric structures.

The use of framing theory, supported by critical practice theory and ethnomethodology, has provided a unique lens with which to explore the complex, situated landscape of this ACT team. An optometrist will use a refractor in order to manipulate different combinations of lenses to determine an eyeglasses prescription; this combination of theoretical lenses was the prescription required to respond to my research questions in a unique way and to contribute to knowledge by seeing the questions and answers with a sharper eye. By questioning power, positionality, and social change, critical practice theory brought my attention to noticing actions and interactions beyond the usual concerns of the ACT program, into its unintended side effects, causes, and consequences. Coupled with ethnomethodology, this lens offered a sharper view into my role as the observer and the observed in order to critically explicate the grassroots accomplishment of social relationships and social order. This necessarily required the practice wisdom of service providers and the lived experience of service users as valid ways of knowing the world. Finally, the lens of framing helped me attend to the specific, singular meanings of actions and interactions as so that I could understand how people derive meaning and produce meaning in varying situations and activities. My interdisciplinary perspective challenges the current orthodoxy of mental health practice and places social justice at the centre of the conceptual framework of recovery in order to attend to the macro-level, systemic factors that impact not only a recovery process, but also the construction of recovery-oriented practices.

The study results infer that recovery and inclusion rhetoric have substituted transformative efforts to promote citizenship, partnership, and social justice; thus the mental health system has avoided recognizable institutional change. It seems that by simply naming recovery or citizenship in recent mental health policies we have underestimated institutional stability. Based on the findings of this study I suggest that we review the implications of institutional accompaniment and the potential to renew practice from a recovery-oriented perspective by using fundamentally different rhetoric that is concerned with issues seeking equality and social justice. This can be understood through a discussion around 3 items that are already in their embryonic stages of development in the urban ACT team that participated in this study: 1) relationship-based practice; 2) understanding the relationship with madness; 3) focusing on macro-level theories and practices.

8.2.1 Relationship-based practice

The findings of this research explicate two significant challenges for practice that have already been mentioned but deserve further attention. The first is a diluted and reductionist conception of the service user as an individual whose needs and wishes have less primacy than behaviours and actions that are ‘risky’ or not ‘normal’. The second is the recourse available to service providers who might use legal tools, medication, and coercion or leverage to not only manage risk and difference, but also to attenuate their feelings of hopelessness and helplessness in the face of complexity, risk, and anxiety. The consequence, might be, as suggested by one of the service providers, *Christine,* that the team focuses on task-oriented operations as opposed to the contextual and subjective aspects of the service user and their relationship with the service user.

Relationship-based practice refers to the idea that despite any upheavals or changes to policy, practice, and procedures, the fundamentals of mental health practice will always begin and end with the human encounter (Howe, 1998). As such, the service provider has to be comfortable with the anxiety and malaise that unique relationships might produce. A relationship-based emphasis will help prioritize interventions that include addressing the social and underlying determinants of mental health such as unequal power relationships and systemic violence and discrimination. In this way, relationship-based approaches, not currently part of the fidelity measures for ACT programs, promote specific critical ingredients. These include using macro-level theories of practice such as social justice or human rights to accomplish rights-based mental health services focused on human interactions and the expertise of service users and service providers. The findings of this study not only support the need for further research on the nature of the helping relationship in specialized community mental health teams but also the need for research on the effectiveness of the shared caseload approach. Although some service users may be capable of establishing strong working relationships with multiple team members, others may not find that to be very difficult and overwhelming. There is no empirical basis for assuming the shared caseload approach will be helpful for all who may need the intensive supports, nor that the individual caseload approach will be helpful for all. Based on the findings of this study, the benefits of a strong working relationship may be more critical to the attainment of desired outcomes than the shared caseload approach.

This ACT team, and perhaps even the ACT model of care with its flexible and intense community-based structure, provides fertile ground to spearhead relationship-based practice with mental health service users who are categorized as ‘severe and persistent’. In addition to these support structures, relationship-based care requires training and a reliance on evaluation or measures that emphasize the time and sensitivity required to sustain it. This might include an increased emphasis on open dialogue, reflexivity, and ethical reasoning. With open dialogue there is the space to include both sides of the dialectic. It’s a process that allows us to examine the service user’s social and environmental reality and thus ‘enter’ into her reality (Dewees, 2002). The immediate environment influences daily life and makes reference to the interrelations between the service user and the other people present in her life. Open dialogue is an attempt to reconcile the concerns of every person involved. Thus, it is not just an informal conversation but also a negotiation of meaning that is attributed by each person to their experience, distress, treatment and clinical process. This open dialogue is enriched through a constant reflexive practice. Reflexivity is gaining currency especially regarding working with uncertainty and as part of ethical practice (as opposed to simply following rules and procedures). In a study with mental health social workers, they stated that a combination of autonomy, flexibility, and reflexivity allowed them to practice in a way that was stigma-reducing and community-oriented, thus facilitating recovery-oriented interventions (Khoury &

Rodriguez, 2015). Reflexivity requires critical self-awareness, questioning assumptions about practice, power, and knowledge and paying attention to one's cognitive biases (Fook & Gardner, 2007; Taylor & White, 2000) to develop holistic understandings of service users and anchor theory in practice. This was shown to be productive in expanding practice repertoires in the field of child and family welfare where surveillance, control, and risk management were also dominant approaches (Cruz et al., 2007). Moreover, a relationship-based focus, could help to mitigate the individualizing model of care that might also be a contributing factor to the service providers feeling of helplessness. Fook & Gardner (2007) explain how critical reflexive practice is useful in the face of uncertainty in human service organizations where service providers experience a fear of risk and increased complexity in their practice. By placing the emphasis on singular, individual needs, rather on a homogenization of needs filtered through the status quo service offer, ACT service providers and service users could work together to envision interventions outside of the realm of symptom reduction, hospital avoidance, and a return to normalcy.

8.2.2 Relationship with madness

The findings of this study also point to the evolving dynamic that exists with 'madness'. *Christine's* statement that she has access to 'madness' because she is not scared of it is very profound and can serve as a potential driving force for the development of innovative practice approaches. This study outlined various situations and scenarios in which service providers cite instrumental accountability as a key decision-making factor when constructing interventions. This study has also unearthed the feelings of powerlessness or professional malaise that accompanies the complexity of their work, especially in light of new groups of service users with complex social difficulties such as homelessness. The implicit questions from service providers seem to include “what do we do with this type of suffering? How do we engage with it?”. Once again the team lead suggested that the only way to engage is through outreach, and the development of PRISM is a tangible realization of an intensive community outreach model that reframes the time and space given to service providers to construct, or co-construct interventions. However, this study also suggests that new practices to respond to the complex needs of service users may be germinating, but are slow to flower. It seems that the psychiatric references for this team remain very influential; that is their practice remains institutionalized in a reductionist biomedical framework so attempts at opening up to new approaches fall short.

Ruby, (service provider)*,* spoke about a *‘savoir-être’ or ‘know-how’* in successfully working with a recovery perspective. What kind of recovery-oriented know-how is needed? How does it interact with madness? The answer to these questions lies in the way service providers connect with service users. The ACT team is already developing and pushing forward practices that would allow for a more integral and fundamental transformation regarding not just service providers relationship with madness, but also society’s relationship with madness. The accompaniment of service users in attending to daily life needs, or ‘normal events’, as stated by *Nathan,* is a privileged space in which service providers have the opportunity to create dialogue, build relationships, and understand the singular experiences of the service users. It is also the opportunity for developing a humanistic understanding of structural and symbolic exclusion and inequalities.

The findings of this study also explicate that ‘normalcy’ is a major objective of interventions. Typically this is interpreted as living a normal life as a productive member of the labour market. Since ‘normalcy’ and recovery are inextricably linked in the conceptualization of mental health recovery in this team, it is not surprising then that service providers have low expectations for so many groups of service users. The all-encompassing case management, that includes medication, social, and financial management, is dangerous in that it easily offers an avenue for standardization that does not account for singular experiences. The flexibility that is engrained into this team structure, does not yet offer flexibility in terms of what is 'normal' or in terms of allowing for difference. That is left up to the individual service provider to determine. A reconfigured relationship with madness in psychiatry, with a focus on diversity, would require not just a challenge, but a change, to our understandings of knowledge. Experiential knowledge is vital to recognizing an individual in the context of her specific situation. Experiential knowledge amassed to date demonstrates that many systemic prejudices woven into the fabric of our mental health institutions are in fact colonized representations of suffering and distress. For example, for some people, auditory hallucinations are not a sign of mental ill health and they prefer to be accompanied by these hallucinations (St-Onge et al., 2005).

A pathway that is inspired by the framework of differentiated citizenship is one in which recovery-oriented service providers offer not only accompaniment, hope, and empowerment, but also challenge systemic discrimination, advocate for the rights of people living with mental health problems, and affirm their identities through a focus on diversity. This strengths-based, progressive relationship with madness, grounded in a critical, citizenship-oriented recovery perspective confronts the 'two-track' recovery practice implemented by the participating ACT team. The individual responsibility to recover can be reframed with a strengths-based perspective that has already infiltrated service provider discourse and actions. This means that through a relationship-based practice and a focus on diversity, service providers would need to be offered space and time to focus on accompanying each service user in developing their singular potential. The ACT team's intimacy with each service user, and the potential for them to know, understand, and accept their singular experiences as well as their privileged position in the community, makes it a place and space that has the potential to sustainably and institutionally reconfigure psychiatry's relationship with madness from that of an individual relationship to a broader transformation that could act upon the relationship between society and madness. My observations indicate that currently their potential for transformation is incipient. For example, one service provider reflected to me, during an informal conversation while driving to visit a service user, on how she believes some people are truly experiencing symptoms of psychosis and are disconnected from reality, whilst many have been institutionalized for so long that they have internalized a psychotic identity. As such, she often works hard to influence the team toward allowing service users to take more risks and to hold space for them so that they may live their experiences without fear of further institutionalization. She attributes her ability to do this to the mutual trust and respect she enjoys with the psychiatrists. This example once again touches upon the importance of how situations and experiences are interpreted by service providers - and how the quality of these interpretations, or conceptions, can transform the potential for a relationship and subsequent interventions. In this study the impact of differing interpretations of situations was observed on the construction of interventions. Future research and training, including supervision and reflexivity training, might focus on the quality of these interpretations and the conceptualization of service users so that the micro-level stigmatization inherent in the low expectations of service user potential for recovery can be diminished.

8.2.3 Progress through macro-level theories and practice

Although service providers recognize the existence of social and economic inequalities, the individualized interventions that are mandated as part of the program and enforced by the CSNEM might limit the capacity for service providers to act upon collective and social barriers to recovery. The juxtaposition of recovery on a relatively rigid organizational structure means that its new significance no longer refutes the biomedical perspective of chronicity in mental illness nor does it explicitly acknowledge the social factors that contribute to difficulties. Focusing on social, structural, and symbolic inequalities instead of individual responsibility reveals a larger perspective of recovery and recovery-oriented practice

Service providers explain that structural barriers to integration and inclusion are contributing factors to their feeling of powerlessness and they discuss the discrimination that is central to society's current relationship with madness:

> *à ce moment là, le regard si on veut est plus difficile. Il y a plus de jugement au niveau social, plus d'exclusion, c'est difficile de les faire entrer dans les structures, les institutions, les structures sociales en générales. Ils sont souvent dans des états aussi de précarité. (Angus)*

This citation, and others presented in the findings, indicates that social inequalities and injustices experienced by service users are recognized and considered relevant. However, my observations indicate that in action, they are overlooked in the construction of mental health interventions. This exclusion, as well as, the stigma faced by mental health service users may obscure their capacity to actively participate in society and be recognized for their potential contributions. The reflexive, relationship-based service provider can focus on diversity whilst understanding how society as a structure of meaning effects service user experiences by focusing on broader macro theories and practices such as social justice, human rights, or critical practice theory. Service providers that participated in this study maintained that their role is to help individuals and groups "live as normally as possible by helping them find a job or connect with others despite their illness and the stigma attached to it" and despite the structural barriers such as inadequate housing or poverty. Across the board, service providers reported that in their practice they were unable to get their interactions to line up with how they felt they should or could intervene mostly due to administrative pressure or organizational constraints.

As aforementioned, the conceptual framework of citizenship in conjunction with mental health recovery can assist service providers and service users in considering multiple factors associated with recovery. This means that a recovery-oriented practice would seek to co-develop interventions related to recovery from singular experiences that have unique significance for each person. This could be symptoms, but also homelessness, poverty, diagnostic labelling, isolation, abuse, coercion, stigma, and trauma.

There are important hurdles to jump in order for an ACT program, as it is currently conceived, to be in line with a recovery orientation that challenges both the biomedical and social control aspects of mental health practice and places social determinants of health in a central role to achieving mental health and well-being. However, promoting the above mentioned macro-level theories can reposition mental health practice so that both self-transformation and social transformation are complementary, bi-directional objectives. This refers to a mental health service delivery system organized in a way that will assist practitioners in challenging the status quo and, as articulated by Slade (2010) in Leboutillier et al. (1470), in "becoming social activists who challenge stigma and discrimination, and promoting societal well-being (…) [as] the norm rather than the exception for mental health professionals in the 21st Century". This requires training, research, accessible conferences and research publications, and both public and professional support, to generate an impetus that will fundamentally change institutional practice.

8.3 Directions for future research

The scale of this debate is extensive and multifaceted even at the local level. To generate achievable policy strategies and practice developments with regards to recovery-oriented practice there is a need for more case studies at the local level to allow further understandings of local dimensions of the subject. The values, approaches, and actions and interactions in this urban ACT team relate to the context specificity of all scientific findings (Lincoln & Guba, 1985). What is relevant and important about the above findings are the potentially transversal procedures, actions and interactions, and practices. These can serve as a first case example for a potential aggregation of transformative and innovative practices in intensive community-based mental health teams in Québec. Exploring the following as future research strategies can facilitate the attainment of this goal:

1) understanding how stigma or discrimination has become structured into many of our services institutions, through daily actions and interactions among actors in a mental health team, despite the good will and professionalism of many workers.
2) enabling service providers and service users to reflect on specific practice encounters, helping to identify points of collaboration for co-construction of interventions.

3) engaging diverse groups of service users to tell their story, and capture meaningful images and stories that communicate their lived experience.
4) unearthing biases and multiple meanings of recovery that are not currently included or represented

Future research objectives might include exploring how service providers create opportunities for connecting and dialoguing with service users in different contexts and understanding recovery from multiple, invisible perspectives. This might be done by answering questions about reflexive practice – what are service provider's reflections on the interactions they are having? What about the service users? Does ACT have a role in breaking down barriers with society and in particular with access to leisure, arts, and cultural activities? How can dialogue with service users be opened up? What are the daily, real life challenges and barriers or facilitators faced by service users? This is particularly useful when we talk about reflexive research and reflexive practice so that in educating mental health practitioners, attention can be paid not only to the constraining and enhancing influence of the environment, but also to the way individuals co-construct that environment. In addition, the use of participative action research, including video recall and photovoice, could be useful in engaging multiple, invisible perspective but also as a methodology to reduce bias in social workers and in the development of recovery-oriented social work interventions.

More specifically, in order to further our understanding of the limits and possibilities of community mental health interventions, from the perspective of service users, a network mapping exercise could be fruitful. The present study revealed the importance of human relationships and social connectedness, and the central role that the ACT team unwittingly has as a point of social contact and a social network. Inspired from recent social work research undertaken in the UK on network mapping, further research in Québec could include a detailed mapping of networks of service users to explore the importance of people, places, and activities in supporting a recovery journey and in co-constructing strengths-based, person-centred interventions. This mapping exercise might also build upon the present study in understanding how community mental health teams, including ACT, potentially have a role in co-creating supportive community networks with service users and other community actors.

8.4 Concluding remarks

This research project explored the kinds of practice approaches that are embedded in an ACT team in a specific context (urban, Montreal) and examined how the ACT team itself is affected by the practices, actions, and discourses that are negotiated daily between service users, professionals and other stakeholders. In short, I explored the community mental health practices of an urban ACT team within a framework of progressive representations of mental health recovery. By critically examining the co-construction of professional practice we can begin to answer questions about the relationship between recovery rhetoric and recovery in practice.

The findings indicate that recovery remains part of a normative and reductionist framework often excluding subjective and empirical dimensions of mental health, mental health practice, and the process that is implied by recovery (social connectedness and integration, hope, a journey, quality of life, active citizenship role). Today mental health recovery and the associated practice approaches are typically linked with ideas of hope, empowerment, and participation in intervention planning for the purpose of integration into society through work, school, or stable housing in the community. However due to a reconceptualization of the individual and to medico-legal and administrative pressures these ideas manifest themselves in a paradoxical institutional accompaniment wherein the community mental health team serves as a proxy social network, community housing serves as a proxy admitting unit, and the prospect of recovery is negotiated for groups of service users based on service provider expectations of them. The social change movement is less evident in this contemporary conceptualization of recovery; the role of social inequalities, marginalization, and vulnerability is no longer a consideration in the critical components of recovery and the subsequent development of recovery-oriented practice approaches. Some of the possible challenges of recovery-oriented practice approaches in an ACT team include 1) mitigating the social control features of ACT; 2) surmounting the biomedical focus in psychiatry; 3) transcending a change in the location of practice to effectively implement a change in the approach of practice; 4) accepting the value of experiential based evidence that sometimes belies traditional evidence based medicine. Common issues and tensions faced by the service providers this ACT team include a sense of powerlessness linked to uncertainty, fear of risk, increased complexity, pressure to work to rules and procedures, and a focus on outcomes. This study also identified the need to find ways to continually develop knowledge and practice that fit with this changing and complex context.

In spite of what is often reported about the benefits of recovery-oriented practice and community-based practice in theoretical and policy positions, recovery in practice has only offered some solutions, at the embryonic stage, to the prevailing and persistent vulnerability and marginalization of people living with severe and persistent mental health problems, even across diverse difficulties. The benefits of recovery-oriented practice in its current policy conceptualization have been shown in this study to be neither comprehensive nor do they seem to offer long-term sustainable support to service users.

Thus, this research contributes to burgeoning debates today which argue that recovery as a dominant organizing principle in policy has become co-opted by neoliberal individualism and ignores its original, emancipatory social justice framework. Nevertheless, these paradoxical effects and diluted approaches may be balanced through the explication of potentially transformative structures and approaches in the ACT team. The intimacy, intensity, and flexibility of the ACT program might provide the groundwork for a renewal of practice emphasizing relationship-based practice, reflexivity, dialogue, and a recovery framework that honours suffering and distress and defends social justice, self-determination, citizenship rights, responsibilities, and chosen social roles of each person. The accompaniment of service users in attending to daily life needs can and, perhaps in the context of recovery-oriented, strengths-based, community mental health, should be the opportunity for developing a humanistic understanding of and action against structural and symbolic exclusion and inequality.

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Annex 1 – Reflexivity and personal experience

Creswell (2014) contends that worldviews are shaped by discipline, professional and personal experience, and the influence of mentors or research advisers. To understand my perspective vis à vis the research inquiry I had to be a reflexive researcher who actively searches for and assumes a particular epistemology (Carter and Little, 2007), explicated as critical constructivism in Chapter 3. My critical constructivist position is particularly coherent with my personal and professional orientation in its encouragement and requirement of reflexivity, dialogue, and critical self-reflection.

When discussing reflexivity, I am referring to an awareness of my relationship with the research study and the influence my experiences and beliefs have had on the research. These concerns represent attempts to take into account how, as a professional social worker and as a researcher, my knowledge production shapes reality at the same time as representing it. Moreover, the nonlinear research process itself has shaped the object of inquiry and the subsequent reflections. In both quantitative and qualitative social research studies, data is collected and analyzed in a systematic and rigorous manner (Neuman, 2003). The interpretive nature of qualitative research positions the researcher close to the research setting (Brodsky, 2009; Neuman, 2003) - traditionally, reflexivity guides practitioners and researchers in examining how they go about doing what they do.

The analytical framework of ethnomethodology provides an understanding of reflexivity that is particularly pertinent to this study that is exploring interventions. It calls for a daily examination of everyday practices through self-questioning and self-examination and it underscores the interactional and *in situ* nature of interventions (de Montigny, 2007; Dowling, 2007). In a similar vein, I will make my positionality and reflexive stance explicit to reveal how it relates to methodological considerations. This was vital to reminding me not to become enmeshed in the ACT social world that I was studying and analyzing through close-proximity ethnographic methods.

Ethnomethodological indifference is a term coined by Garfinkel and Sacks (1970) that has been compared to the phenomenological approach of 'bracketing' (Dowling, 2007) and the critical ethnographic stance of ethical responsibility for a researcher's positionality (Madison, 2012). This indifference is described by ten Have (2004) as clearing "the way for a reconsideration of practical phenomena in their local specifics, rather than in terms of any pre-given schema or rule-set" (p.176). However, bracketing, or *indifference*, is a contested and inconsistent tool that is used at different times, by different researchers, in the research process. Like Giorgi (1998) in Tufford & Newman (2010), I 'bracketed' by suspending those biases, with the assistance of journal writing, memos, and conversations with my research director in order to reflect on the forces that have shaped my interpretations during the writing and analysis process. However, I also developed an awareness of my preconceptions prior to the beginning of the study through reflexive journal writing through out my doctoral studies. Bracketing, or *ethnomethodological indifference*, as a reflexive process is useful in shifting the centre of attention so that I could listen to and be aware of invisible actions, hidden interactions, and silenced voices. This reflexive process also offered the opportunity for me to continue to be aware of power differentials between myself and participants, attend to the particular contexts of my observations and interviews, and remain keenly attentive to my positionality.

My disciplinary background in mental health social work has influenced the design of this study. For several years I practiced social work in a psychiatric hospital, first as an intern and then as a professional. During this time I practiced as a caseworker, liaison agent, coordinator, and a clinical-administrative manager. As a social worker in a psychiatric institution I was perplexed by the ways in which I could fulfill my profession's social justice mission whilst working in a technocratic and overly medicalized work environment. My practice was initially informed by anti-oppression social work theory and practice (Dominelli, 2001), which has been described as part of 'modern critical social work theory and practice' (Healy, 2005); early on in my career, a colleague introduced me to the concept of recovery. I was increasingly aware of how institutional contexts could facilitate or hinder recovery-oriented mental health social work practice. It is thus that links began to form between work organization and social work practice and the influence of our overarching government policies. I was personally challenged by the operationalization of recovery practice and what it meant to my colleagues and myself. More recently, I have questioned the role of ideology in manufacturing the recovery perspective in use, especially as citizenship begins to take on a central role in mental health and recovery policies (Government of Québec, 2015). These questions have been distilled to the problem statement at hand: the influence of community mental health programs on service providers and service users not only as social actors but also as political and cultural actors. The overarching research bias, which I have referred to in my notes as 'anticipated dilemmas', can be stated as assuming that there will be paradoxes and complexities to supporting marginalized members of society in ACT program due to a reductionist and hegemonic biomedical paradigm and that the role of the ACT service providers will thus be mitigated by a focus on symptom reduction and medication adherence. My bias is also attributed to a critical awareness of the neoliberal ideology present in mental health policies that might influence the relationships within an ACT team so that they risk professionalization and individualization to the point of ignoring a broader, collective and social scope.

My experience and role as a mental health social worker have been key to this project. I was able to obtain entry and acceptance by the team of professionals on the ACT team in large part because I was a peer and a colleague who lived and experienced similar professional challenges and passion. During the field work of this study I interacted not only with mental health professionals and psychiatrists, groups that have always made up my work contacts, but also with people living with severe mental health problems and who face important structural and social barriers such as extreme poverty, isolation and stigma. Knowing my professional background gave them the opportunity to discuss their own practice and concerns openly with me – and my background positioned me well to already have a foundational understanding and appreciation for the in-group language and behaviour.

Annex 2 – Initial interview indicators, objectives and questions

Indicateurs	Objectifs	Questions
Théories de **rétablissement**	Décrire la compréhension des dimensions et définitions du rétablissement selon les participants. Comprendre comment c'est définitions sont mis en oeuvre dans leurs vie quotidien: • Quels facteurs facilitateurs et contraignants existe dans leur quotidien? • Est-ce qu'il existe des convergences ou divergences dans la conceptualisation du rétablissement?	Qu'est que 'le rétablissement' veut dire pour vous et pourquoi? Les approches axés sur le rétablissement. Qu'est que cela signifie pour vous? Est-ce que c'est pertinent pour les interventions au sein de votre équipe/le programme SI? Qu'est qui différencie une personne qui est en processus de rétablissement d'une qui ne l'est pas? Comment est-ce que vous savez si quelqu'un (*si vous)* est en rétablissement? Qu'est qui sont les barrières au rétablissement? À une pratique axée sur le rétablissement? Les facilitateurs?
Participation dans la construction des pratiques	Déterminer leur perception du niveau de participation de la personne utilisatrice dans la planification des interventions, dans le contact ou liaison avec organisations en dehors de l'institution, et dans les processus quotidiens du programme SI. Déterminer la manière dont les besoins, opinions, objectives et satisfaction des personnes utilisatrices est assimilé dans la pratique.	Décrivez une situation dans laquelle vous (ou votre patient) était directement impliqué dans la planification de l'intervention.
Flexibilité dans la	Comprendre comment les	Est-ce que vous pouvez décrire la

choix des approaches, dans les types d'intéractions	participants utilise leur temps et marge de manoeuvre afin de promouvoir le bien être, autonomie, rétablissement des personnes utilisatrices Déterminer si des espaces démocratiques sont établis qui offre le temps pour une relation bidirectionnel qui pourra donner lieu à la négociation et co-construction des interventions	structure de votre programme et équipe? Qu'est ce que sont vos responsabilités (accompagnement, assistance, filet de sécurité, psychothérapie….) Qu'est ce qui est votre role vis à vis la médication? Si votre role consiste à des interventions médical ou liées aux médicaments, quelle place est-ce que ceux-ci prennent par rapport aux autres interventions/responsabilités? Est-ce que vous devez respecter une certaine limite dans le temps et l'intensité de vos interactions? Décrivez comment votre expérience et perspective subjective influence la construction des pratiques professionnelles? Quel est le role de expérience, dialogue et négociation dans la constructions des pratiques? Comment est-ce que vous définissez les liens thérapeutiques que vous tissez avec les personnes utilisatrices (*intervenants).*
Mobilisation Communautaire	Décrire les transformations/changements individuels (micro) et social (macro) viser par les participants et le programme SI Comprendre la vision d'intégration qui est véhiculé par les participants Déterminer les façons que les ressources communautaires sont mobilisées	Certaines personnes pensent qu'un manque de contact avec leur communauté local est une barrière à leur processus de rétablissement. Qu'est que vous en pensez? Quel regard portez-vous sur la situation des personnes qui vivent des problèmes de santé mentale dans notre société/collectivité ? Quelles seraient selon vous les principales qualités d'une société inclusive et accueillante pour les

		personnes qui vivent avec des problèmes de santé mentale? Le role du SI? Décrivez une situation dans laquelle vous étiez en liaison avec la communauté. Est-ce que vous avez assister (étiez assister) dans des objectifs qui ne sont pas directement lié à votre diagnostic psychiatrique?
Processus de rétablissement (pour personnes utilisatrices seulement)	Dégager des représentations subjectives de l'expérience de difficultés en santé mentale, rétablissement et de l'expérience au sein du programme SI. Comprendre comment le SI s'inscrit dans la vie de la personne utilisatrice dans un sens très large. Expliciter plusieurs processus subjectifs qui répondent au constat dans la littérature que les expériences des problèmes de santé mentale et le processus de rétablissement sont hétérogènes.	Quel est le role du programme SI dans votre vie? Quelles sont les principales difficultés rencontrées par les personnes dans leur processus de rétablissement selon vous? Qu'est-ce que ça prend, concrètement, pour être (ou se sentir) en processus de rétablissement?

Annex 3 – Interview grill, service providers

Le rétablissement en santé mentale dans la cite : Perspectives de divers acteurs sur un territoire urbain.

Grille d'entrevue – professionnels et psychiatres

1. Portrait professionnel

2. Portrait des personnes utilisatrices

3. Le programme de suivi intensif dans la communauté CSSS Jeanne Mance/CH Notre Dame

4. Interventions

5. Rétablissement

1. Portrait professionnel

- Quelles sont vos fonctions actuellement?
    - Qu'est ce que cela implique?
    - Comment est-ce que cela diffère des autres intervenants avec des professions différents?

- Depuis combien de temps travaillez-vous avec l'équipe SI de Jeanne Mance?
    - Pourquoi est-ce que vous avez voulu travailler en SI?
    - Qu'est ce qui était vos expériences antérieures de formation ou travail?

- Comment se déroule une journée de travail « type » pour vous? Une semaine de travail « type »?

2. Portrait des personnes utilisatrices

- Quel regard portez-vous sur la situation des personnes qui vivent des problèmes de santé mentale dans notre société/collectivité ?

- Quelles sont les problématiques vécues par les personnes utilisatrices
    - Qu'est ce qui a causé, selon vous, ces problèmes/souffrances?
        - Comment est-ce que **x** à causé **y**? etc..
- Les personnes doivent-elle répondre à certains critères pour fréquenter le programme SI?
    - Lequels?
    - Êtes-vous en accord avec ces critères? Pourquoi ou pourquoi pas?
- Est-ce que les personnes usagères fréquentent parallèlement d'autres ressources?
- Quels sont les principaux apports du SI pour les personnes utilisatrices
- Quelles ont les principales limites su SI pour les personnes utilisatrices?
    - Qu'est ce qui pourrait être fait de plus?
    - Pour certains type de clients (itinérance)

3. Le programme de suivi intensif dans la communauté CSSS Jeanne Mance/CH Notre Dame

- Comment décririez-vous le projet thérapeutique du SI?
    - Les buts visés? (raison d'être/objectif général. Illustrez propos)
    - Est-ce que les personnes usagères participent à leur définition? Si, ou i à quel moment et de quelle façon?
    - Qu'est ce que différencie le SI des autres équipes 2ieme ou 3ieme ligne?
    - Qu'est ce que différencie le SI du SIV?
    - Le role du Centre d'Excellence?
    - Sont quoi les repères théoriques? (philosophie d'intervention, approches préconisés)
        - Quel rôle jouent-ils dans les pratiques? Exemples?
        - Comment vous situez-vous par rapport à ces repères théoriques? Quels seraient vos repères théoriques idéaux?
        - Les limites?
- Quels sont les principaux volets du SI (Med drop, rencontre suivi, lien avec communauté, etc..)?
    - Est-ce que les personnes utilisatrices ont le choix de participer à l'un ou l'autre volet?
    - Comment voyez vous le role de l'intervenant dans le processus de traitement?
- Pouvez vous me parler de comment une personne accède au programme SI.
    - Qui fait quoi pour évaluation/accueil?
- Est-ce qu'il y a une limite dans la durée du suivi? Comment vous sentez vous par rapport à cette limite?
- De quelles façons le programme SI vous semble-t-il aidant pour les personnes concernées?
    - Contribue-t-il à des processus d'amélioration?
    - Contribue-t-il à des processus de transformation?

- Selon vous qu'est ce que le programme SI peut apporter à la vie des personnes utilisatrices?
    - Diriez-vous que les personnes utilisatrices trouvent un apport du programme?

4. Interventions

- Quels sont les objectifs des interventions?
    - Quelle est la place de la médication et réduction de symptômes dans vos interventions?
    - Quelle est la place donner au ressources communautaires dans l'élaboration de vos interventions?
    - Quelle est la flexibilité ou autonomie que vous avez dans l'élaboration ou l'exécution de votre travail?
    - Quelle est la place des personnes utilisatrices dans l'élaboration ou l'exécution des interventions?
- Comment voyez-vous le rôle et la place de la personne utilisatrice dans le processus de traitement?
    - Décrivez une situation dans laquelle la personne utilisatrice était directement impliquée dans la planification de l'intervention.
    - Comment se passe-t-il l'élaboration du PII?
- Quelles sont les principales difficultés rencontrées dans le suivi?
    - Pour la personne utilisatrice?
    - Pour vous?
- Comment est-ce que vous intervenez avec des personnes en situation d'itinérance?
- Que se passe t il face aux situations difficiles? Avec les personnes qui vivent et expriment des problèmes et souffrances particulièrement intense ou de crise?
        - Est-ce que SI est en mesure d'accueillir et d'accompagner les personnes qui vivent des souffrances et problèmes lourds? Comment? Limites?
        - Ou le SI réfère-t-elle les personnes?
- Pouvez vous me décrire une intervention dite 'réussi'? un 'échec'?
- Quels sont les limites que vous rencontrer dans votre travail? (ou éléments de contention de la pratique) Pourquoi? Moyens thérapeutiques?
- Que serait votre projet thérapeutique idéal?

5. Rétablissement

- Qu'est ce que signifie l'espoir?
    - Le rétablissement?
    - Le pouvoir d'agir?
    - La folie?

- Décrivez une situation dans laquelle vous étiez en liaison avec la communauté. Est-ce que vous avez assister (étiez assister) dans des objectifs qui ne sont pas directement lié au diagnostic psychiatrique?
- Certaines personnes pensent qu'un manque de contact avec leur communauté local est une barrière à leur processus de rétablissement. Qu'est que vous en pensez?
- Quelles seraient selon vous les principales qualités d'une société inclusive et accueillante pour les personnes qui vivent avec des problèmes de santé mentale? Le role du SI dans la sensibilisation de la société vis à vis l'inclusion?
- Les approches axés sur le rétablissement. Qu'est que cela signifie pour vous? Est-ce que c'est pertinent pour les interventions au sein de votre équipe/le programme SI?
- Qu'est qui différencie une personne qui est en processus de rétablissement d'une qui ne l'est pas? Comment est-ce que vous savez si quelqu'un est en rétablissement?
- Qu'est qui sont les barrières au rétablissement? À une pratique axée sur le rétablissement? Les facilitateurs?

Annex 4 – Interview grill, service users

Le rétablissement en santé mentale dans la cité : Perspectives de divers acteurs sur un territoire urbain.

Grille d'entrevue – personnes usagères

1. Portrait personnel

2. Arrivée au programme de suivi intensif dans la communauté CSSS Jeanne Mance/CH Notre Dame : contexte, attentes et accueil reçu
3. Perspectives et attentes aujourd'hui
4. Rétablissement

1. Portrait personnel

- Pouvez-vous me parler un peu de vous?
    - De ce qui compte pour vous ?
- Pouvez-vous me parler un peu de votre vie aujourd'hui (de façon concrète)?
    - Les choses que vous aimez et que vous aimez faire dans votre vie aujourd'hui?
    - Les choses que vous aimez moins?
    - Les choses que vous souhaiteriez trouver dans votre vie actuelle et qui ne s'y trouvent pas ou pas assez ?

- Pouvez-vous me parler de vos conditions de vie? (logement, sources de revenu, etc.)
    - Quels sont les aspects de vos conditions de vie qui vous satisfont?
    - Quels sont les aspects de vos conditions de vie qui vous satisfont moins?
    - Quelles sont les principales difficultés que vous rencontrez au niveau de vos conditions de vie?

- Pouvez-vous me parler de votre vie quotidienne?
    - Quels sont les aspects de votre vie quotidienne que vous appréciez le plus?

    - Quels sont les aspects que vous appréciez moins?
    - Quelles sont les principales difficultés que vous rencontrez dans votre vie quotidienne?

- Pouvez-vous me parler de vos activités, des activités que vous aimez? (*Si la personne n'a pas déjà répondu*.)
    - Des activités que vous aimeriez faire?

- Qui sont les personnes significatives de votre entourage?

- Êtes-vous membre d'un groupe, d'un organisme, d'une ressource?
    - Lequel, lesquels?
    - À quelle fréquence y allez-vous?
- Depuis combien de temps est vous avec l'équipe SI?
    - Et pour combien de temps encore?

2. Arrivée au programme de suivi intensif dans la communauté CSSS Jeanne Mance/CH Notre Dame : contexte, attentes et accueil reçu

- Qu'est-ce qui vous a amenée au programme SI?
    - Avez-vous été référée par une autre ressource ou un autre service? Laquelle?
    - Qu'est ce qui se passait dans votre vie à ce moment-là par rapport votre vécu de souffrance, aux problèmes de santé mentale que vous viviez?
    - Qu'est ce qui a causé, selon vous, ces problèmes/souffrances?
        - Comment est-ce que **x** à causé **y**? etc..
- Qu'est ce que vous attendiez à votre arrivée au programme SI?
- Comment cela s'est-il passé à votre arrivée?
    - Par qui et comment avez-vous été accueillie?
    - Qu'Est ce qui vous a été proposé au départ comme démarche? Comment vous sentiez-vous par rapport à ce qui vous était proposé?
    - Quelle était votre place ou role dans les décisions par rapport aux démarches à suivre?
    - Est-ce qu'une fréquence de visite/type de visite a été établi? Par qui?
    - Est-ce que des objectifs ont été fixés? Par qui? Quels étaient ces objectifs?
    - Est-ce que des ententes et des engagements on été pris?
    - Est-ce qu'on vous a parlé de la philosophie ou de l'approche de SI?

        - Qu’avez vous envie de dire de cela?

3. Perspectives et attentes aujourd’hui

- Pouvez vous me parler du modèle ou concept des équipes suivi intensif?
    - Raison d’être /objectif général?
    - Comment est-ce que le SI est significatif dans votre vie?
- Pouvez vous me décrire votre relation avec l’équipe (intervenants) aujourd’hui?
    - Le type d’interaction
    - De quoi parler vous avec les intervenants? De quel fréquence? Qu’est ce que vous faits avec les intervenants (ex. magasinage, visite logements, visite O.C., visite DPJ, visite famille, accompagnement aux rdv médicales ou autre)?
    - Comment sont vos rapports avec les intervenants?
        - Quelle est l’importance de ces rapports pour vous?
    - Qu’est ce que vous travaillez (le rapport à vous même? À votre histoire? Aux autres? Vos difficultés? Autres?)
        - Est-ce que vous pouvez me décrire une situation ou le SI vous a aider ou accompagner à tissé des liens avec votre communauté?
    - Qu’est-ce qui vous plait de cet relation?
    - Qu’est ce qui vous plait moins de cet relation?
- Est-ce qu’il y a des choses que vous ne travaillez pas ou pas suffisamment avec l’équipe SI? Si ou :
    - Lesquelles?
    - Comment vous sentez-vous par rapport à cette limite du programme?

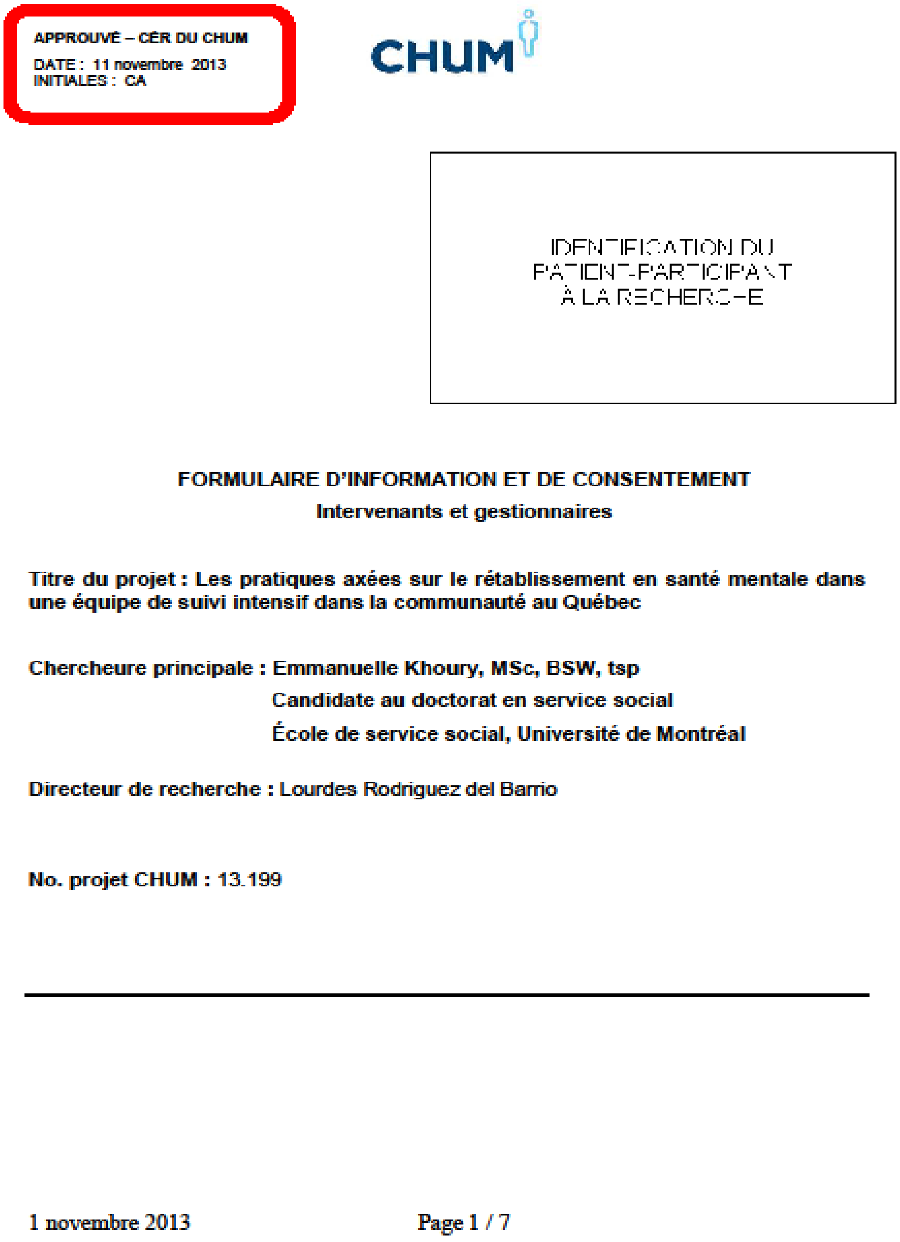
- Quel est le rôle du programme SI dans votre vie?
    - Quelle place et quelle importance a pour vous les relations avec les intervenants?
        - Avez vous développé des liens particuliers avec un ou une intervenante?
        - Comment sentez-vous que cet intervenant vous perçoit ou vous comprend? (experience, souffrance, problèmes de santé mentale, rêves)
    - Est-ce que le fait d’avoir un suivi a changé quelque chose pour vous?
        - Par rapport à vous même, aux autres, et la communauté?
        - Par rapport à vos désir et vos projets?
    - Qu’est ce qui est le plus aidant?

    - Qu’est ce qui vous plait moins au SI?
    - Qu’est ce que vous auriez souhaité trouver au SI que vous n’y avez pas trouvé?

4. Rétablissement

- Qu’est ce que signifie l’espoir?
    - Le rétablissement?
    - Le pouvoir d’agir?
- Quelle place prend le rétablissement dans votre vie?
    - Dans le suivi avec SI?
- Décrivez une situation dans laquelle vous étiez directement impliquée dans la planification de l’intervention.
- Décrivez une situation dans laquelle vous étiez en liaison avec la communauté.
    - Est-ce que vous étiez assisté dans des objectifs qui ne sont pas directement lié à votre diagnostic psychiatrique?
    - Est-ce qu’il y a d’autres ressources ou services d’aide dans votre vie actuellement?
        - Lesquels?
        - Est ce que vous poursuivez ailleurs qu’au SI une thérapie?
        - Comment situez-vous ce que vous faites à l’hôpital de jour par rapport à ces autres démarches?
- Certaines personnes pensent qu’un manque de contact avec leur communauté local est une barrière à leur processus de rétablissement. Qu’est que vous en pensez?
- Quel regard portez-vous sur la situation des personnes qui vivent des problèmes de santé mentale dans notre société/collectivité ?
- Quelles seraient selon vous les principales qualités d’une société inclusive et accueillante pour les personnes qui vivent avec des problèmes de santé mentale? Le rôle du SI?
- Les approches axés sur le rétablissement. Qu’est que cela signifie pour vous? Est-ce que c’est pertinent pour les interventions au sein de votre équipe/le programme SI?
- Qu’est qui différencie une personne qui est en processus de rétablissement d’une qui ne l’est pas? Comment est-ce que vous savez si quelqu’un (*si vous)* est en rétablissement?
- Quelles sont les principales difficultés rencontrées par les personnes dans leur processus de rétablissement selon vous?
- Qu’est-ce que ça prend, concrètement, pour être (ou se sentir) en processus de rétablissement?
    - Comment est-ce que vous voyez votre avenir?

Annex 5 – Consent forms, service providers and service users



APPROUVÉ – CÉR DU CHUM
DATE : 11 novembre 2013
INITIALES : CA

CHUM

IDENTIFICATION DU
PATIENT-PARTICIPANT
À LA RECHERCHE

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT
Intervenants et gestionnaires

Titre du projet : Les pratiques axées sur le rétablissement en santé mentale dans une équipe de suivi intensif dans la communauté au Québec

Chercheure principale : Emmanuelle Khoury, MSc, BSW, tsp
Candidate au doctorat en service social
École de service social, Université de Montréal

Directeur de recherche : Lourdes Rodriguez del Barrio

No. projet CHUM : 13.199

1 novembre 2013 Page 1 / 7

PRÉAMBULE

Nous sollicitons votre participation à un projet de recherche parce que vous êtes un intervenant ou gestionnaire du programme Suivi Intensif dans la communauté. Cependant, avant d'accepter de participer à ce projet et de signer ce formulaire d'information et de consentement, veuillez prendre le temps de lire, de comprendre et de considérer attentivement les renseignements qui suivent.

Ce formulaire peut contenir des mots que vous ne comprenez pas. Nous vous invitons à poser toutes les questions que vous jugerez utiles à la chercheure responsable du projet ou aux autres membres du personnel affecté au projet de recherche et à leur demander de vous expliquer tout mot ou renseignement qui n'est pas clair.

NATURE ET OBJECTIFS DU PROJET

Cette recherche vise à découvrir et expliciter les pratiques professionnelles dans une équipe de Suivi Intensif (SI) dans la communauté dans le cadre d'une perspective de rétablissement à partir du point de vue de différents acteurs impliqués dans le champ de la santé mentale (personnes utilisatrices, intervenants, gestionnaires). Cette recherche permettra ainsi d'identifier les pratiques d'intervention au sein d'une équipe SI et déterminer comment ces pratiques d'intervention sont en lien avec les valeurs, les dimensions et les approches qui caractérisent le rétablissement. La recherche vise aussi à déterminer les perspectives de rétablissement élaborées par les acteurs du terrain, au plus près des enjeux de l'expérience et de la pratique quotidienne, et si ces perspectives correspondent aux pratiques d'intervention actuelles. De plus, cette étude vise à dégager les pratiques professionnelles novatrices qui sont construites en collaboration avec les personnes utilisatrices.

NOMBRE DE PARTICIPANTS ET DURÉE DE LA PARTICIPATION

Environ 20 participants dont des intervenants, gestionnaires et utilisateurs seront recrutés pour ce projet de recherche au CHUM. Votre participation à ce projet de recherche durera un maximum de 6 mois. Durant cette période la chercheure sera en observation à raison de 2 à 3 jours par semaine avec divers participants et selon leur disponibilité.

NATURE DE LA PARTICIPATION DEMANDÉE ET DÉROULEMENT DE L'ÉTUDE

Si vous acceptez de participer à ce projet et après avoir signé le présent formulaire d'information et de consentement, votre participation consistera à :

1) accorder la permission à la chercheure d'observer, de façon non-participante, les interactions et interventions au bureau et dans les milieux de vie de personnes usagères à plusieurs reprises et selon votre niveau de confort pendant une période de 6 mois (maximum) : rencontres individuelles avec utilisateurs participants, réunions d'équipes professionnelles, rencontres en thérapie de groupe, visites avec utilisateurs participants aux ressources communautaires et visites au domicile et/ou rencontre avec utilisateurs participants à l'extérieur de l'institution.

2) rencontrer la chercheure lors d'une entrevue individuelle d'une durée de 60 minutes. Les questions posées porteront sur le rétablissement, votre définition du rétablissement, ce qui aide ou nuit au rétablissement en santé mentale, et vos réflexions sur les interventions et approches qui sont construites à l'intérieur de

l'équipe SI. Cette entrevue sera enregistrée, avec votre autorisation, sur support audio afin d'en faciliter ensuite la transcription. Le lieu et le moment de l'entrevue seront déterminés selon vos disponibilités.

3) Durant l'observation et l'entrevue la chercheure tiendra un journal de bord et prendra des notes.

RISQUES ET INCONVÉNIENTS

Il n'y a pas de risque particulier à participer à ce projet. Le principal inconvénient associé à la participation à cette étude réside dans le temps exigé par la participation.

Lors de l'entrevue individuelle, vous pourrez à tout moment refuser de répondre à une question ou même mettre fin à l'entrevue. La chercheure sera extrêmement attentive à respecter les limites que vous souhaiterez assigner à l'entrevue. Les questions et les observations portent sur vos interventions et approches professionnels. Ce n'est pas une recherche évaluative et vos réponses demeurent confidentielles. Votre supérieur ne sera pas informé du contenu de l'entrevue. Il n'y a pas des questions personnelles. S'il y a des questions plus difficiles, la chercheure va trouver, avec le participant, la meilleure façon de l'aborder. La chercheure est aussi intervenante donc, si nécessaire, elle essayera de trouver ou fournir des références pertinentes qui ne sont pas à l'intérieur de son département.

Vous pourrez refuser la présence de la chercheure lors de certaines activités, dans le cadre des observations.

Le fait de participer ou non au projet de recherche n'aura aucune répercussion sur votre implication dans le programme Suivi Intensif dans la communauté.

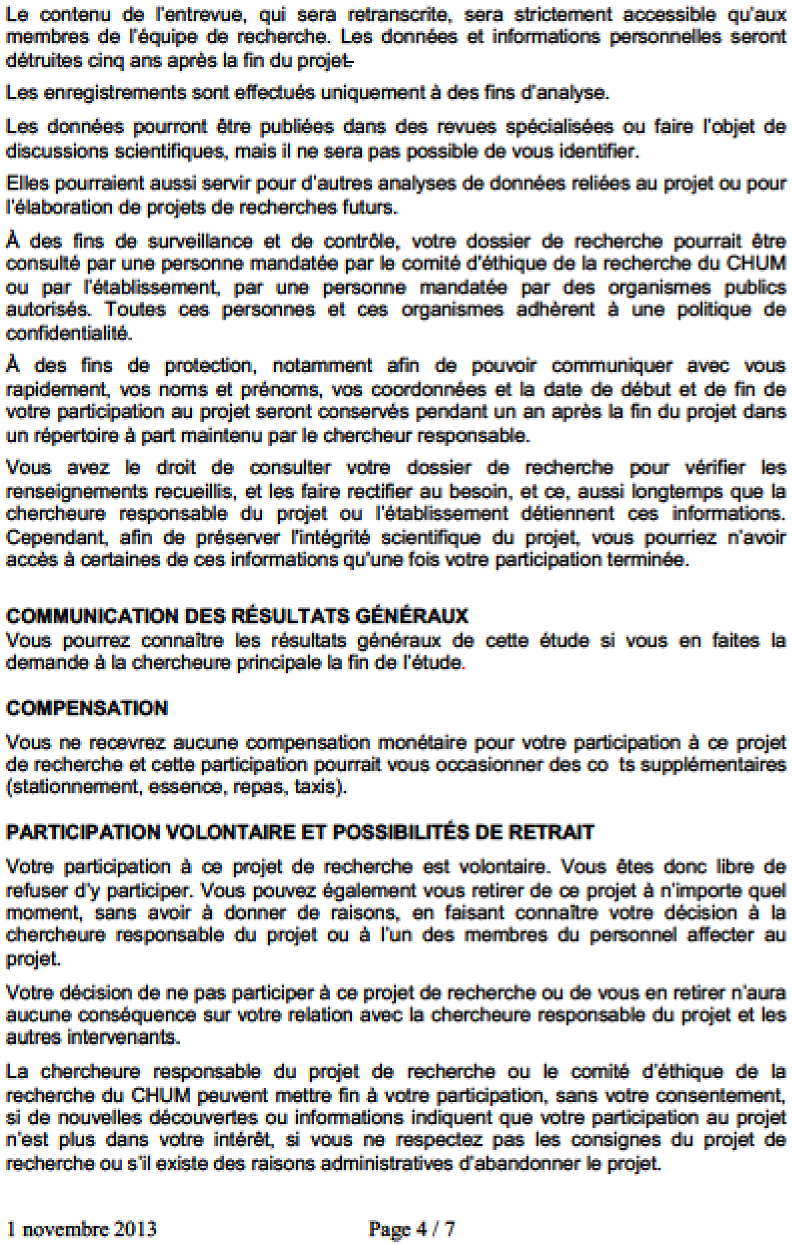
AVANTAGES

Il se peut que vous retiriez un bénéfice personnel de votre participation à ce projet de recherche, mais on ne peut vous l'assurer. À tout le moins, les résultats obtenus contribueront à l'avancement des connaissances dans ce domaine.

CONFIDENTIALITÉ

Durant votre participation à ce projet, la chercheure responsable ainsi que son personnel recueilleront et consigneront dans un dossier de recherche les renseignements vous concernant. Seuls les renseignements nécessaires pour répondre aux objectifs scientifiques de ce projet seront recueillis.

Tous les renseignements recueillis demeureront strictement confidentiels dans les limites prévues par la loi. Afin de préserver votre identité et la confidentialité des renseignements, vous ne serez identifié(e) que par un numéro de code. La clé du code reliant votre nom à votre dossier de recherche sera conservée par la chercheure responsable.



Le contenu de l'entrevue, qui sera retranscrite, sera strictement accessible qu'aux membres de l'équipe de recherche. Les données et informations personnelles seront détruites cinq ans après la fin du projet.

Les enregistrements sont effectués uniquement à des fins d'analyse.

Les données pourront être publiées dans des revues spécialisées ou faire l'objet de discussions scientifiques, mais il ne sera pas possible de vous identifier.

Elles pourraient aussi servir pour d'autres analyses de données reliées au projet ou pour l'élaboration de projets de recherches futurs.

À des fins de surveillance et de contrôle, votre dossier de recherche pourrait être consulté par une personne mandatée par le comité d'éthique de la recherche du CHUM ou par l'établissement, par une personne mandatée par des organismes publics autorisés. Toutes ces personnes et ces organismes adhèrent à une politique de confidentialité.

À des fins de protection, notamment afin de pouvoir communiquer avec vous rapidement, vos noms et prénoms, vos coordonnées et la date de début et de fin de votre participation au projet seront conservés pendant un an après la fin du projet dans un répertoire à part maintenu par le chercheur responsable.

Vous avez le droit de consulter votre dossier de recherche pour vérifier les renseignements recueillis, et les faire rectifier au besoin, et ce, aussi longtemps que la chercheure responsable du projet ou l'établissement détiennent ces informations. Cependant, afin de préserver l'intégrité scientifique du projet, vous pourriez n'avoir accès à certaines de ces informations qu'une fois votre participation terminée.

COMMUNICATION DES RÉSULTATS GÉNÉRAUX

Vous pourrez connaître les résultats généraux de cette étude si vous en faites la demande à la chercheure principale la fin de l'étude.

COMPENSATION

Vous ne recevrez aucune compensation monétaire pour votre participation à ce projet de recherche et cette participation pourrait vous occasionner des coûts supplémentaires (stationnement, essence, repas, taxis).

PARTICIPATION VOLONTAIRE ET POSSIBILITÉS DE RETRAIT

Votre participation à ce projet de recherche est volontaire. Vous êtes donc libre de refuser d'y participer. Vous pouvez également vous retirer de ce projet à n'importe quel moment, sans avoir à donner de raisons, en faisant connaître votre décision à la chercheure responsable du projet ou à l'un des membres du personnel affecter au projet.

Votre décision de ne pas participer à ce projet de recherche ou de vous en retirer n'aura aucune conséquence sur votre relation avec la chercheure responsable du projet et les autres intervenants.

La chercheure responsable du projet de recherche ou le comité d'éthique de la recherche du CHUM peuvent mettre fin à votre participation, sans votre consentement, si de nouvelles découvertes ou informations indiquent que votre participation au projet n'est plus dans votre intérêt, si vous ne respectez pas les consignes du projet de recherche ou s'il existe des raisons administratives d'abandonner le projet.

Si vous vous retirez ou êtes retiré(e) du projet, l'information déjà obtenue dans le cadre de ce projet sera conservée aussi longtemps que nécessaire pour rencontrer les exigences réglementaires.

Si vous décidez de vous retirer de la recherche après l'entrevue, vous pouvez communiquer avec la chercheure, au numéro de téléphone indiqué ci-dessous. À votre demande, tous les renseignements qui vous concernent pourront être détruits. Dans le cas de votre retrait précoce, les enregistrements seront détruits. Cependant, après le déclenchement du processus de publication (où seules pourront être diffusées des informations ne permettant pas de vous identifier), il sera impossible de détruire les analyses et les résultats portant sur vos données.

Toute nouvelle connaissance acquise durant le déroulement du projet qui pourrait affecter votre décision de continuer d'y participer vous sera communiquée sans délai verbalement et par écrit.

INDEMNISATION EN CAS DE PRÉJUDICE ET DROITS DU SUJET DE RECHERCHE

En acceptant de participer à cette étude, vous ne renoncez à aucun de vos droits ni ne libérez les chercheurs ou l'établissement de leurs responsabilités légales et professionnelles.

PERSONNES-RESSOURCES

Si vous avez des questions concernant le projet de recherche ou si vous éprouvez un problème que vous croyez relié à votre participation au projet de recherche, vous pouvez communiquer avec la chercheure responsable du projet de recherche au numéro suivant :

Emmanuelle Khoury : [redacted]

Pour toute question concernant vos droits en tant que participant à ce projet de recherche ou si vous avez des plaintes ou des commentaires à formuler vous pouvez communiquer avec le commissaire local aux plaintes et à la qualité des services de l'Hôpital Notre-Dame du CHUM au 514-890-8000, poste 26047 ou l'Hôtel-Dieu du CHUM au 514-890-8000, poste 12761 ou l'Hôpital St-Luc du CHUM au numéro 514-890-8000, poste 36366.

SURVEILLANCE DES ASPECTS ÉTHIQUES

Le comité d'éthique de la recherche du CHUM a approuvé ce projet de recherche et en assure le suivi. De plus, il approuvera au préalable toute révision et toute modification apportée au formulaire d'information et de consentement et au protocole de recherche.

CONSENTEMENT

Avant de signer et dater le présent formulaire de consentement, j'ai reçu des explications complètes sur les méthodes et les moyens qui seront utilisés dans l'étude ainsi que sur les désagréments, les risques et les effets indésirables qui pourraient y être associés.

J'ai lu et j'ai eu suffisamment de temps pour comprendre pleinement les renseignements présentés ci-dessus concernant cette étude. J'ai eu l'occasion de poser toutes mes questions et on y a répondu à ma satisfaction. Je suis libre de poser d'autres questions à n'importe quel moment. J'accepte de plein gré de signer ce formulaire de consentement. Je recevrai un exemplaire de ce formulaire après l'avoir signé et daté. En apposant ma signature sur ce formulaire, je ne renonce cependant à aucun de mes droits légaux ni ne libère la chercheure et l'hôpital de leur responsabilité civile et professionnelle.

Consentez-vous à l'enregistrement audio de l'entrevue ?
OUI ☐ NON ☐

____
Nom et signature du participant à la recherche Date

Signature de la personne qui a obtenu le consentement si différente de la chercheure responsable du projet de recherche

J'ai expliqué au participant à la recherche les termes du présent formulaire d'information et de consentement et j'ai répondu aux questions qu'il m'a posées.

____
Nom et signature de la personne qui obtient le consentement Date

Engagement de la chercheure

Je certifie qu'on a expliqué au participant à la recherche les termes du présent formulaire d'information et de consentement, que l'on a répondu aux questions que le participant à la recherche avait à cet égard et qu'on lui a clairement indiqué qu'il demeure libre de mettre un terme à sa participation.

Je m'engage, avec l'équipe de recherche, à respecter ce qui a été convenu au formulaire d'information et de consentement et à en remettre une copie signée et datée au participant à la recherche.

____
Nom et signature **de la chercheure** responsable du projet de recherche Date

SIGNATURE D'UN TÉMOIN

OUI ☐ NON ☐

La signature d'un témoin est requise pour les raisons suivantes :

☐ Difficulté ou incapacité à lire - La personne (témoin impartial) qui appose sa signature ci-dessous atteste qu'on a lu le formulaire de consentement et qu'on a expliqué précisément le projet au (à la) participant(e), qui semble l'avoir compris (se).

☐ Incompréhension de la langue du formulaire de consentement - La personne qui appose sa signature ci-dessous a fait fonction d'interprète pour le ou la participant(e) au cours du processus visant à obtenir le consentement

---

Nom (en lettres moulées) Signature du témoin Date

Veillez noter :

Il faut consigner dans le dossier de recherche du (de la) participant(e), le cas échéant, d'autres renseignements sur l'aide fournie au cours du processus visant à obtenir le consentement.

APPROUVÉ – CÉR DU CHUM
DATE : 11 novembre 2013
INITIALES : CA

CHUM

IDENTIFICATION DU
PATIENT-PARTICIPANT
À LA RECHERCHE

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT

Usagers

Titre du projet : Les pratiques axées sur le rétablissement en santé mentale dans une équipe de suivi intensif dans la communauté au Québec

Chercheure principale : Emmanuelle Khoury, MSc, BSW, tsp
Candidate au doctorat en service social
École de service social, Université de Montréal

Directeur de recherche : Lourdes Rodriguez del Barrio

No. projet CHUM : 13.199

PRÉAMBULE

Nous sollicitons votre participation à un projet de recherche parce que vous êtes une personne utilisatrice du programme Suivi Intensif dans la communauté. Cependant, avant d'accepter de participer à ce projet et de signer ce formulaire d'information et de consentement, veuillez prendre le temps de lire, de comprendre et de considérer attentivement les renseignements qui suivent.

Ce formulaire peut contenir des mots que vous ne comprenez pas. Nous vous invitons à poser toutes les questions que vous jugerez utiles à la chercheure responsable du projet ou aux autres membres du personnel affecté au projet de recherche et à leur demander de vous expliquer tout mot ou renseignement qui n'est pas clair.

NATURE ET OBJECTIFS DU PROJET

Cette recherche vise à découvrir et expliciter les pratiques professionnelles dans une équipe de suivi intensif (SI) dans la communauté dans le cadre d'une perspective de rétablissement à partir du point de vue de différents acteurs impliqués dans le champ de la santé mentale (personnes utilisatrices, intervenants, gestionnaires). Cette recherche permettra ainsi d'identifier les pratiques d'intervention au sein d'une équipe SI et déterminer comment ces pratiques d'intervention sont en lien avec les valeurs, les dimensions et les approches qui caractérisent le rétablissement. La recherche vise aussi à déterminer les perspectives de rétablissement élaborées par les acteurs du terrain, au plus près des enjeux de l'expérience et de la pratique quotidienne, et si ces perspectives correspondent aux pratiques d'intervention actuelles. De plus, cette étude vise à dégager les pratiques professionnelles novatrices qui sont construites en collaboration avec les personnes utilisatrices.

NOMBRE DE PARTICIPANTS ET DURÉE DE LA PARTICIPATION

Environ 20 participants dont des intervenants, gestionnaires et utilisateurs seront recrutés pour ce projet de recherche au CHUM. Votre participation à ce projet de recherche durera un maximum de 6 mois. Durant cette période la chercheure sera en observation à raison de 2 à 3 jours par semaine avec divers participants et selon leur disponibilité.

NATURE DE LA PARTICIPATION DEMANDÉE ET DÉROULEMENT DE L'ÉTUDE

Si vous acceptez de participer à ce projet et après avoir signé le présent formulaire d'information et de consentement, votre participation consistera à:

1) accorder la permission à la chercheure d'observer, de façon non-participante, les interactions et interventions au bureau de votre intervenant et dans votre milieu de vie à plusieurs reprises et selon votre niveau de confort pendant une période de 6 mois (maximum) : rencontres individuelles avec intervenants, rencontres en thérapie de groupe, visites avec intervenant aux ressources communautaires et visites au domicile et/ou rencontre avec intervenant à l'extérieur de l'institution.

2) rencontrer la chercheure lors d'une entrevue individuelle d'une durée de 60 minutes. Les questions posées porteront sur le rétablissement, votre définition du rétablissement, ce qui aide ou nuit au rétablissement en santé mentale, votre cheminement dans cela (s'il y a lieu), et vos réflexions sur les interventions et approches qui sont construites à l'intérieur de l'équipe SI. Certaines questions explorent plus particulièrement votre

trajectoire, les contraintes et les espaces d'ouverture au sein de l'équipe de suivi intensif que vous avez rencontrées face à vos projets.
Cette entrevue sera enregistrée, avec votre autorisation, sur support audio afin d'en faciliter transcription. Le lieu et le moment de l'entrevue seront déterminés selon vos disponibilités. Au besoin, l'entrevue pourra se dérouler en deux étapes, sur deux jours différents.

3) Durant l'observation et l'entrevue la chercheure tiendra un journal de bord et prendra des notes.

RISQUES ET INCONVÉNIENTS

Il n'y a pas de risque particulier à participer à ce projet. Le principal inconvénient associé à la participation à cette étude réside dans le temps exigé par la participation.

Cependant, il est possible que certaines questions puissent raviver des souvenirs liés à une expérience désagréable. Si cela se produit, n'hésitez pas à en parler avec la chercheure. S'il y a lieu, elle pourra vous référer à une personne-ressource.
Lors de l'entrevue individuelle, vous pourrez à tout moment refuser de répondre à une question ou même mettre fin à l'entrevue. La chercheure sera extrêmement attentive à respecter les limites que vous souhaiterez assigner à l'entrevue.

Vous pourrez refuser la présence de la chercheure lors de certaines activités, dans le cadre des observations.

Le fait de participer ou non au projet de recherche n'aura aucune répercussion sur votre implication dans le programme Suivi Intensif dans la communauté.

AVANTAGES

Il se peut que vous retiriez un bénéfice personnel de votre participation à ce projet de recherche, mais on ne peut vous l'assurer. À tout le moins, les résultats obtenus contribueront à l'avancement des connaissances dans ce domaine.

CONFIDENTIALITÉ

Durant votre participation à ce projet, la chercheure responsable ainsi que son personnel recueilleront et consigneront dans un dossier de recherche les renseignements vous concernant. Seuls les renseignements nécessaires pour répondre aux objectifs scientifiques de ce projet seront recueillis.

Ces renseignements peuvent comprendre les informations contenues dans vos dossiers médicaux concernant votre état de santé passé et présent, vos habitudes de vie ainsi que les résultats de toutes les procédures que vous aurez à subir durant ce projet. Votre dossier peut aussi comprendre d'autres renseignements tels que votre nom, votre sexe, votre date de naissance et votre origine ethnique.

Tous les renseignements recueillis demeureront strictement confidentiels dans les limites prévues par la loi. Afin de préserver votre identité et la confidentialité des renseignements, vous ne serez identifié(e) que par un numéro de code. La clé du code reliant votre nom à votre dossier de recherche sera conservée par la chercheure responsable.

Le contenu de l'entrevue, qui sera retranscrite, sera strictement accessible qu'aux membres de l'équipe de recherche. Les données et informations personnelles seront détruites cinq ans après la fin du projet.

Les enregistrements sont effectués uniquement à des fins d'analyse.

Les données pourront être publiées dans des revues spécialisées ou faire l'objet de discussions scientifiques, mais il ne sera pas possible de vous identifier.

Elles pourraient aussi servir pour d'autres analyses de données reliées au projet ou pour l'élaboration de projets de recherches futurs.

À des fins de surveillance et de contrôle, votre dossier de recherche ainsi que vos dossiers médicaux pourront être consultés par une personne mandatée par le comité d'éthique de la recherche du CHUM ou par l'établissement, par une personne mandatée par des organismes publics autorisés. Toutes ces personnes et ces organismes adhèrent à une politique de confidentialité.

À des fins de protection, notamment afin de pouvoir communiquer avec vous rapidement, vos noms et prénoms, vos coordonnées et la date de début et de fin de votre participation au projet seront conservés pendant un an après la fin du projet dans un répertoire à part maintenu par le chercheur responsable.

Vous avez le droit de consulter votre dossier de recherche pour vérifier les renseignements recueillis, et les faire rectifier au besoin, et ce, aussi longtemps que le chercheur responsable du projet ou l'établissement détiennent ces informations. Cependant, afin de préserver l'intégrité scientifique du projet, vous pourriez n'avoir accès à certaines de ces informations qu'une fois votre participation terminée.

COMMUNICATION DES RÉSULTATS GÉNÉRAUX

Vous pourrez connaître les résultats généraux de cette étude si vous en faites la demande la chercheure principale la fin de l'étude.

COMPENSATION

Vous ne recevrez aucune compensation monétaire pour votre participation à ce projet de recherche et cette participation pourrait vous occasionner des co ts supplémentaires (stationnement, essence, repas, taxis).

PARTICIPATION VOLONTAIRE ET POSSIBILITÉS DE RETRAIT

Votre participation à ce projet de recherche est volontaire. Vous êtes donc libre de refuser d'y participer. Vous pouvez également vous retirer de ce projet à n'importe quel moment, sans avoir à donner de raisons, en faisant connaître votre décision à la chercheure responsable du projet ou à l'un des membres du personnel affecté au projet.

Votre décision de ne pas participer à ce projet de recherche ou de vous en retirer n'aura aucune conséquence sur la qualité des soins et des services auxquels vous avez droit ou sur votre relation avec la chercheure responsable du projet et les autres intervenants.

La chercheure responsable du projet de recherche ou le comité d'éthique de la recherche du CHUM peuvent mettre fin à votre participation, sans votre consentement, si de nouvelles découvertes ou informations indiquent que votre participation au projet n'est plus dans votre intérêt, si vous ne respectez pas les consignes du projet de recherche ou s'il existe des raisons administratives d'abandonner le projet.

Si vous vous retirez ou êtes retiré(e) du projet, l'information déjà obtenue dans le cadre de ce projet sera conservée aussi longtemps que nécessaire pour assurer votre sécurité et aussi celles des autres sujets de recherche et rencontrer les exigences réglementaires.

Si vous décidez de vous retirer de la recherche après l'entrevue, vous pouvez communiquer avec la chercheure, au numéro de téléphone indiqué ci-dessous. À votre demande, tous les renseignements qui vous concernent pourront être détruits. Dans le cas de votre retrait précoce, les enregistrements seront détruits. Cependant, après le déclenchement du processus de publication (où seules pourront être diffusées des informations ne permettant pas de vous identifier), il sera impossible de détruire les analyses et les résultats portant sur vos données.

Toute nouvelle connaissance acquise durant le déroulement du projet qui pourrait affecter votre décision de continuer d'y participer vous sera communiquée sans délai verbalement et par écrit.

INDEMNISATION EN CAS DE PRÉJUDICE ET DROITS DU SUJET DE RECHERCHE

Si vous deviez subir quelque préjudice que ce soit par suite de toute procédure reliée à l'étude, vous recevrez tous les soins et services requis par votre état de santé, sans frais de votre part.

En acceptant de participer à cette étude, vous ne renoncez à aucun de vos droits ni ne libérez les chercheurs ou l'établissement de leurs responsabilités légales et professionnelles.

PERSONNES-RESSOURCES

Si vous avez des questions concernant le projet de recherche ou si vous éprouvez un problème que vous croyez relié à votre participation au projet de recherche, vous pouvez communiquer avec la chercheure responsable du projet de recherche aux numéro suivant :

Emmanuelle Khoury : [redacted]

Pour toute question concernant vos droits en tant que participant à ce projet de recherche ou si vous avez des plaintes ou des commentaires à formuler vous pouvez communiquer avec le commissaire local aux plaintes et à la qualité des services de l'Hôpital Notre-Dame du CHUM au 514-890-8000, poste 26047 ou l'Hôtel-Dieu du CHUM au 514-890-8000, poste 12761 ou l'Hôpital St-Luc du CHUM au numéro 514-890-8000, poste 36366.

SURVEILLANCE DES ASPECTS ÉTHIQUES

Le comité d'éthique de la recherche du CHUM a approuvé ce projet de recherche et en assure le suivi. De plus, il approuvera au préalable toute révision et toute modification apportée au formulaire d'information et de consentement et au protocole de recherche.

CONSENTEMENT

Avant de signer et dater le présent formulaire de consentement, j'ai reçu des explications complètes sur les méthodes et les moyens qui seront utilisés dans l'étude ainsi que sur les désagréments, les risques et les effets indésirables qui pourraient y être associés.

J'ai lu et j'ai eu suffisamment de temps pour comprendre pleinement les renseignements présentés ci-dessus concernant cette étude. J'ai eu l'occasion de poser toutes mes questions et on y a répondu à ma satisfaction. Je suis libre de poser d'autres questions à n'importe quel moment. J'accepte de plein gré de signer ce formulaire de consentement. Je recevrai un exemplaire de ce formulaire après l'avoir signé et daté. Un exemplaire sera également déposé à mon dossier médical. En conséquence, je comprends que cette information sera disponible à toute personne ou compagnie à qui je donnerai accès à mon dossier médical. En apposant ma signature sur ce formulaire, je ne renonce cependant à aucun de mes droits légaux ni ne libère la chercheure et l'hôpital de leur responsabilité civile et professionnelle.

J'autorise la chercheure à informer mon médecin traitant de ma participation à ce projet:

Oui ☐

Non ☐

Nom et adresse du médecin traitant :

____

Consentez-vous à l'enregistrement audio de l'entrevue ?
OUI ☐ NON ☐

____
Nom et signature du participant à la recherche Date

Signature de la personne qui a obtenu le consentement si différente de la chercheure responsable du projet de recherche

J'ai expliqué au participant à la recherche les termes du présent formulaire d'information et de consentement et j'ai répondu aux questions qu'il m'a posées.

____
Nom et signature de la personne qui obtient le consentement Date

Engagement de la chercheure

Je certifie qu'on a expliqué au participant à la recherche les termes du présent formulaire d'information et de consentement, que l'on a répondu aux questions que le participant à la recherche avait à cet égard et qu'on lui a clairement indiqué qu'il demeure libre de mettre un terme à sa participation.

Je m'engage, avec l'équipe de recherche, à respecter ce qui a été convenu au formulaire d'information et de consentement et à en remettre une copie signée et datée au participant à la recherche.

____

Nom et signature **de la chercheure** responsable du projet de recherche Date

SIGNATURE D'UN TÉMOIN

OUI ☐ NON ☐

La signature d'un témoin est requise pour les raisons suivantes :

☐ Difficulté ou incapacité à lire - La personne (témoin impartial) qui appose sa signature ci-dessous atteste qu'on a lu le formulaire de consentement et qu'on a expliqué précisément le projet au (à la) participant(e), qui semble l'avoir compris (se).

☐ Incompréhension de la langue du formulaire de consentement - La personne qui appose sa signature ci-dessous a fait fonction d'interprète pour le ou la participant(e) au cours du processus visant à obtenir le consentement

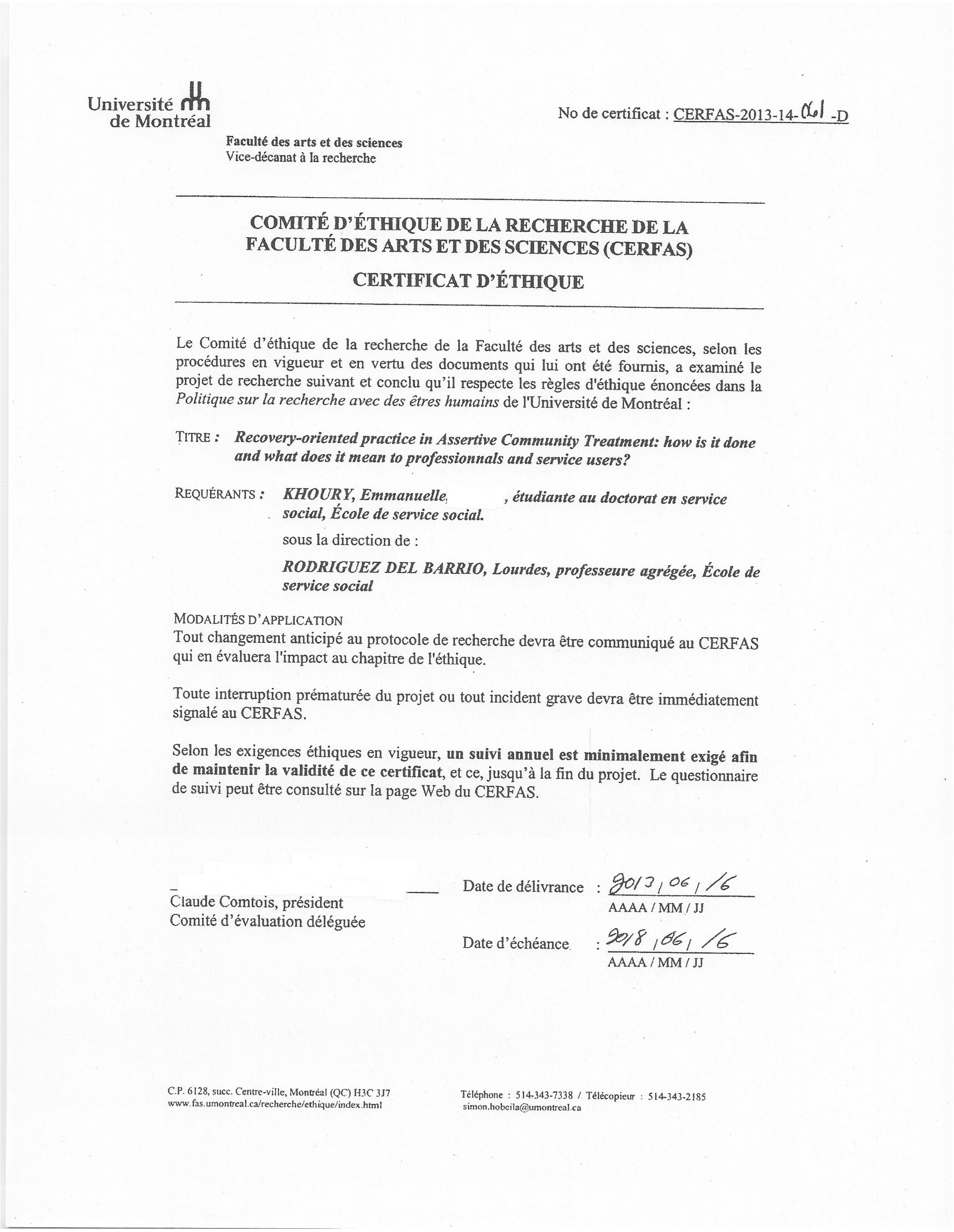
____

Nom (en lettres moulées) Signature du témoin Date

Veillez noter :

Il faut consigner dans le dossier de recherche du (de la) participant(e), le cas échéant, d'autres renseignements sur l'aide fournie au cours du processus visant à obtenir le consentement.

Annex 6a – Ethics certificate, CERFAS



Université de Montréal

No de certificat : CERFAS-2013-14-061-D

Faculté des arts et des sciences
Vice-décanat à la recherche

COMITÉ D'ÉTHIQUE DE LA RECHERCHE DE LA FACULTÉ DES ARTS ET DES SCIENCES (CERFAS)

CERTIFICAT D'ÉTHIQUE

Le Comité d'éthique de la recherche de la Faculté des arts et des sciences, selon les procédures en vigueur et en vertu des documents qui lui ont été fournis, a examiné le projet de recherche suivant et conclu qu'il respecte les règles d'éthique énoncées dans la *Politique sur la recherche avec des êtres humains* de l'Université de Montréal :

TITRE : ***Recovery-oriented practice in Assertive Community Treatment: how is it done and what does it mean to professionnals and service users?***

REQUÉRANTS : ***KHOURY, Emmanuelle, , étudiante au doctorat en service social, École de service social.***

sous la direction de :

RODRIGUEZ DEL BARRIO, Lourdes, professeure agrégée, École de service social

MODALITÉS D'APPLICATION

Tout changement anticipé au protocole de recherche devra être communiqué au CERFAS qui en évaluera l'impact au chapitre de l'éthique.

Toute interruption prématurée du projet ou tout incident grave devra être immédiatement signalé au CERFAS.

Selon les exigences éthiques en vigueur, **un suivi annuel est minimalement exigé afin de maintenir la validité de ce certificat**, et ce, jusqu'à la fin du projet. Le questionnaire de suivi peut être consulté sur la page Web du CERFAS.

Claude Comtois, président
Comité d'évaluation déléguée

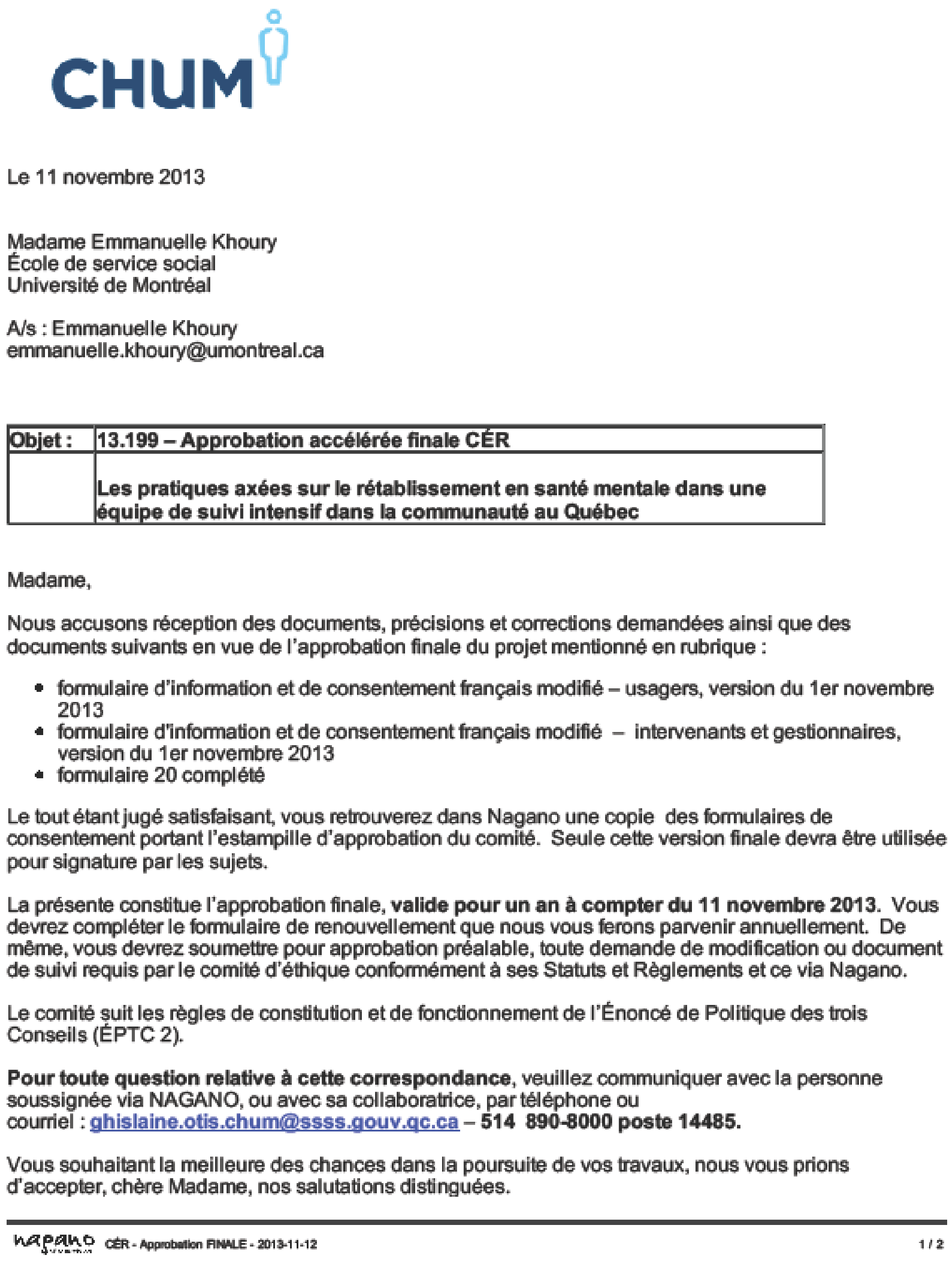
Date de délivrance : 2013 / 06 / 16
AAAA / MM / JJ

Date d'échéance : 2018 / 06 / 16
AAAA / MM / JJ

C.P. 6128, succ. Centre-ville, Montréal (QC) H3C 3J7
www.fas.umontreal.ca/recherche/ethique/index.html

Téléphone : 514-343-7338 / Télécopieur : 514-343-2185
simon.bobeila@umontreal.ca

Annex 6b – Ethics certificate, CHUM



CHUM

Le 11 novembre 2013

Madame Emmanuelle Khoury
École de service social
Université de Montréal

A/s : Emmanuelle Khoury
emmanuelle.khoury@umontreal.ca

Objet :	**13.199 – Approbation accélérée finale CÉR**
	Les pratiques axées sur le rétablissement en santé mentale dans une équipe de suivi intensif dans la communauté au Québec

Madame,

Nous accusons réception des documents, précisions et corrections demandées ainsi que des documents suivants en vue de l'approbation finale du projet mentionné en rubrique :

- formulaire d'information et de consentement français modifié – usagers, version du 1er novembre 2013
- formulaire d'information et de consentement français modifié – intervenants et gestionnaires, version du 1er novembre 2013
- formulaire 20 complété

Le tout étant jugé satisfaisant, vous retrouverez dans Nagano une copie des formulaires de consentement portant l'estampille d'approbation du comité. Seule cette version finale devra être utilisée pour signature par les sujets.

La présente constitue l'approbation finale, **valide pour un an à compter du 11 novembre 2013**. Vous devrez compléter le formulaire de renouvellement que nous vous ferons parvenir annuellement. De même, vous devrez soumettre pour approbation préalable, toute demande de modification ou document de suivi requis par le comité d'éthique conformément à ses Statuts et Règlements et ce via Nagano.

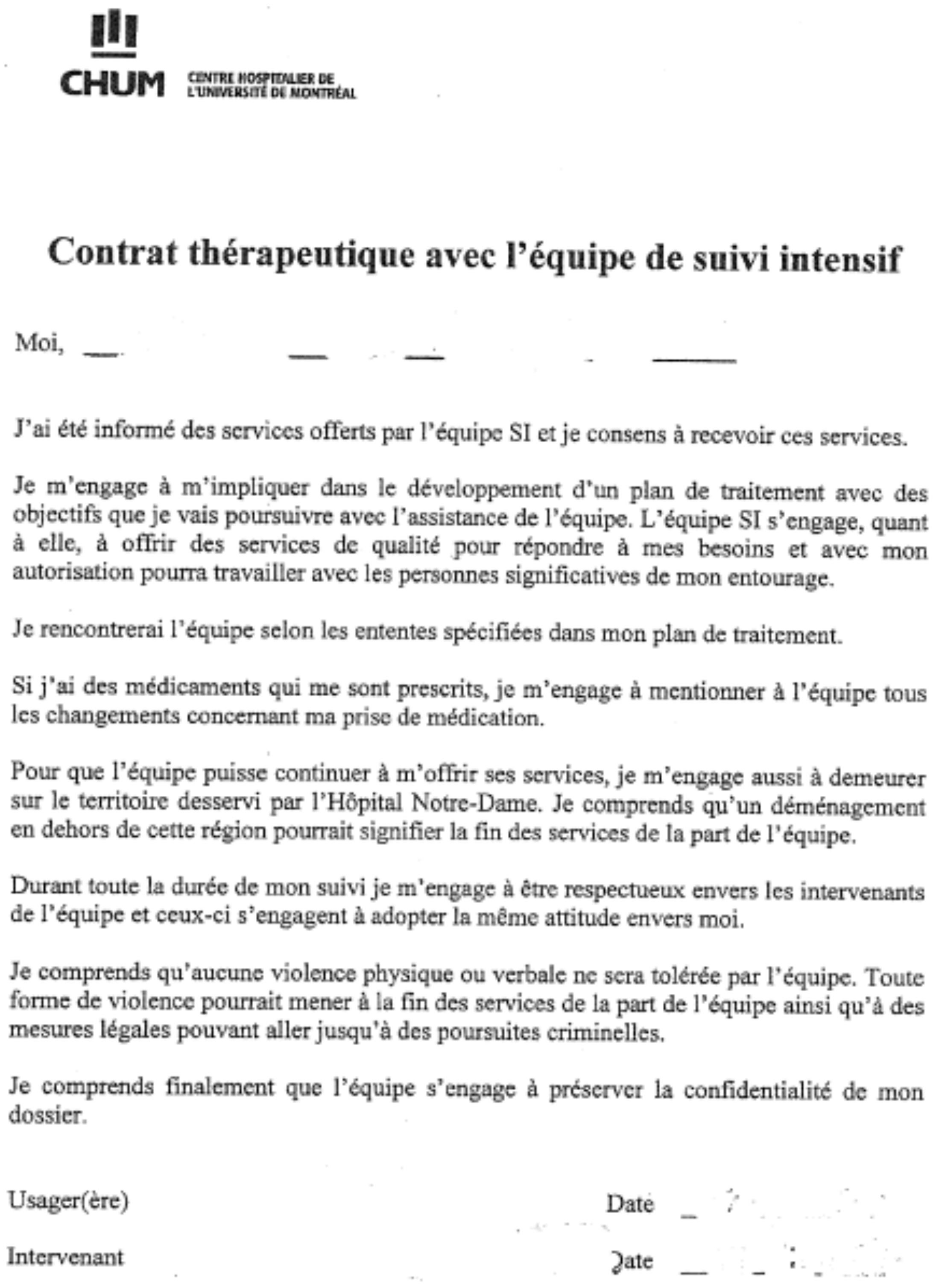
Le comité suit les règles de constitution et de fonctionnement de l'Énoncé de Politique des trois Conseils (ÉPTC 2).

Pour toute question relative à cette correspondance, veuillez communiquer avec la personne soussignée via NAGANO, ou avec sa collaboratrice, par téléphone ou courriel : ghislaine.otis.chum@ssss.gouv.qc.ca – **514 890-8000 poste 14485.**

Vous souhaitant la meilleure des chances dans la poursuite de vos travaux, nous vous prions d'accepter, chère Madame, nos salutations distinguées.

Camille Assemat
Vice-présidente
Comité d'éthique de la recherche du CHUM

Annex 7 - Therapeutic contract



CHUM CENTRE HOSPITALIER DE L'UNIVERSITÉ DE MONTRÉAL

Contrat thérapeutique avec l'équipe de suivi intensif

Moi, ___

J'ai été informé des services offerts par l'équipe SI et je consens à recevoir ces services.

Je m'engage à m'impliquer dans le développement d'un plan de traitement avec des objectifs que je vais poursuivre avec l'assistance de l'équipe. L'équipe SI s'engage, quant à elle, à offrir des services de qualité pour répondre à mes besoins et avec mon autorisation pourra travailler avec les personnes significatives de mon entourage.

Je rencontrerai l'équipe selon les ententes spécifiées dans mon plan de traitement.

Si j'ai des médicaments qui me sont prescrits, je m'engage à mentionner à l'équipe tous les changements concernant ma prise de médication.

Pour que l'équipe puisse continuer à m'offrir ses services, je m'engage aussi à demeurer sur le territoire desservi par l'Hôpital Notre-Dame. Je comprends qu'un déménagement en dehors de cette région pourrait signifier la fin des services de la part de l'équipe.

Durant toute la durée de mon suivi je m'engage à être respectueux envers les intervenants de l'équipe et ceux-ci s'engagent à adopter la même attitude envers moi.

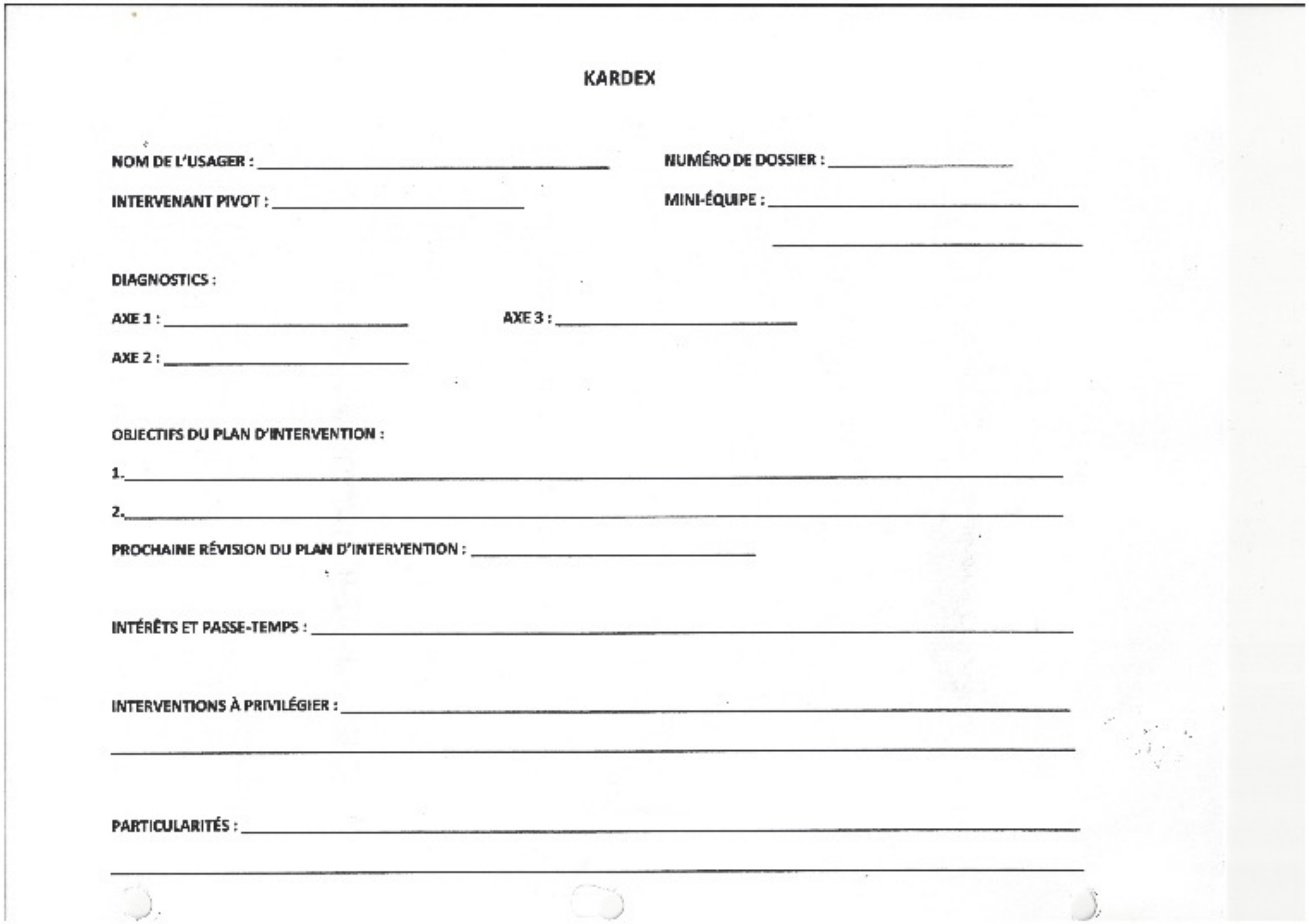
Je comprends qu'aucune violence physique ou verbale ne sera tolérée par l'équipe. Toute forme de violence pourrait mener à la fin des services de la part de l'équipe ainsi qu'à des mesures légales pouvant aller jusqu'à des poursuites criminelles.

Je comprends finalement que l'équipe s'engage à préserver la confidentialité de mon dossier.

Usager(ère) Date ___

Intervenant Date ___

Annex 8 - Kardex example



KARDEX

NOM DE L'USAGER : ____________________ NUMÉRO DE DOSSIER : ____________

INTERVENANT PIVOT : ______________ MINI-ÉQUIPE : __________________

____

DIAGNOSTICS :

AXE 1 : ______________ AXE 3 : ______________

AXE 2 : ______________

OBJECTIFS DU PLAN D'INTERVENTION :

1.____

2.____

PROCHAINE RÉVISION DU PLAN D'INTERVENTION : ________________

INTÉRÊTS ET PASSE-TEMPS : ____

INTERVENTIONS À PRIVILÉGIER : ____________________________________

____

PARTICULARITÉS : ____

____