

Embedded Police Officers in Assertive Community Treatment: Impacts on Service Delivery and Health-Related Outcomes

by

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Abstract

Background: The deinstitutionalization of patients from psychiatric institutions and deficiencies in community treatment have been linked to a mental health “crisis” in Canadian cities. Municipal police departments have vocalized concerns that they have become 24-hour responders to this crisis, that it is taxing their resources beyond capacity, and that it is fostering a criminal justice response to mental illness. To address these concerns, some municipal police departments have advocated for the creation of Assertive Community Treatment (ACT) teams with embedded officers. Although the ACT model has been the focus of rigorous scientific scrutiny, modification with the presence of embedded officers remains largely unevaluated. This study seeks to address this knowledge gap through research focusing on the experiences of service providers and consumers. **Methods:** This research is informed by grounded theory ethnographic methods. Data collection included 47 in-depth qualitative interviews with both service providers (N = 23) and consumers (N = 24) as well as over 90 hours of focused observational fieldwork and informal interviews. **Findings:** Results reveal that embedding police officers in the ACT model shapes the experiences of service providers and consumers in multiple domains of their treatment interactions. Findings demonstrate the significance of relationships in the ACT model, the importance of secure housing as a component of treatment, service-provider struggles between identities as agents of social control and agents of change, and the impacts of systemic pressures for “flow” in and out of ACT teams. **Conclusions:** Police-embedded ACT offers a unique adaptation with the potential to address psychiatric, psychosocial, and criminogenic needs. However, findings of this study raise concerns, including coercion, lack of consumer autonomy, and potential blurring between treatment and social control. Police-embedded ACT and the potential power imbalances the model can create call for independent and transparent oversight as well as consumer involvement in future research and evaluation.

Keywords: Assertive Community Treatment; community mental health; concurrent disorders; Forensic Assertive Community Treatment.

I dedicate this thesis to Rob — never forgotten. No more pain.

“. . . there is nothing either good or bad, but thinking makes it so.”

– William Shakespeare, *Hamlet*, Act 2, Scene 2

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List of Acronyms

ACCESS	AIDS Care Cohort to Evaluate Exposure to Survival Services
ACT	Assertive Community Treatment
ARYS	At-Risk Youth Study
ASD	autism spectrum disorder
ASP	Assertive Short-term Program
BC	British Columbia
BCCSU	British Columbia Centre on Substance Use
CSS	community support society
CTO	community treatment order
DACTS	Dartmouth Assertive Community Treatment Scale
DWI	daily witnessed ingestion (of medication)
FACT	Flexible or Functional Assertive Community Treatment
FASD	fetal alcohol spectrum disorder
ForACT	Forensic Assertive Community Treatment
ICM	intensive case management
NP-ACT	non-profit ACT team
PHC	Providence Health Care
RCT	randomized controlled trial
RTA	Residential Tenancy Act
SFU	Simon Fraser University
UBC	The University of British Columbia
VICOT	Victoria Integrated Community Outreach Team
VIDUS	The Vancouver Injection Drug Users Study
VPD	Vancouver Police Department

Glossary

Aid Society	A pseudonym for a non-profit service provider in the research setting that assists people with navigating the housing system and accessing social services.
At Home	The At Home/Chez Soi Housing First Study.
Community Support Society (CSS)	A pseudonym for a non-profit service provider in the setting where data collection took place. This organization operates several housing sites in this setting.
Met Community Building	A pseudonym for a supported housing building operated by the Community Support Society. This building is located within The Block neighbourhood. I conducted observational fieldwork in this building because early interviews suggested that it would offer a setting for concentrated public interactions with police embedded in ACT service delivery because a number of ACT consumers resided in or visited it.
The Block	A pseudonym for a neighbourhood in an urban setting in British Columbia, Canada where ethnographic fieldwork was conducted. The Block has been characterized by other researchers as an epicentre of poverty and marginalization.

Chapter 1. Introduction

This thesis presents results of an independent qualitative research project undertaken towards the partial fulfillment of requirements for the degree of Doctor of Philosophy (PhD) in the Faculty of Health Sciences at Simon Fraser University (SFU). The focus of this doctoral research is the phenomenon of embedding police officers within Assertive Community Treatment (ACT) teams. This introductory chapter will situate readers with respect to this research project through a brief description of the ACT model, a summary of the geographic context where police-embedded ACT emerged, as well as reflections on my social and theoretical positioning as a researcher.

While the ACT model itself has proliferated for several decades and has been the subject of rigorous research, the addition of police officers appears to be largely undocumented and unevaluated in literature from the mental health and public health fields. This unique phenomenon of embedding police officers within the ACT model is the focus of my research project, with the goal of beginning to describe and understand how this modification shapes experiences of service providers and consumers. To meet this goal, my research has been informed by grounded theory ethnography. These methods helped me to describe how embedding officers within the ACT model can shape experiences and health-related outcomes in multiple domains of ACT treatment. The objectives of this study were to: (1) examine the experiences of service providers, including police officers, working on ACT teams with embedded police officers; (2) examine the experiences of consumers receiving services from ACT teams with embedded police officers; and (3) document and analyze the service delivery of police-embedded ACT teams through participant-observer data collection.

1.1. What is ACT?

Although a comprehensive description of the ACT model will follow in subsequent chapters, a brief summary will be provided at this point to begin situating readers with respect to the context of this research project. So, what is ACT, and what does it do? Readers will note that such questions anthropomorphize a treatment model, and I have done this intentionally to emphasize the dominant phrasing used in many research publications and by most of my study participants. Through such language, the

ACT model becomes personified as something that in and of itself can do things. However, at its core, ACT is simply a rigorously standardized model of community mental health treatment. ACT teams are composed of clinicians from different health disciplines who deliver services through outreach to consumers who experience severe mental illness (Bond & Drake, 2015; Phillips et al., 2001). The ACT model is usually focused upon providing services to consumers who have disengaged from conventional mental health treatment and who have high use of crisis-based services such as emergency hospital presentations (Chow & Priebe, 2013; Dixon, 2000). Contemporary ACT teams are designed to provide wraparound services such as medication administration and monitoring, assistance with housing, and counselling (Bond & Drake, 2015; Fries & Rosen, 2011). The ratio of service providers to consumers is low in order to facilitate frequent treatment contacts and the ability to support consumers in working towards both short- and long-term goals (Dixon et al., 1997; Morrissey et al., 2007; Salyers et al., 2013; Stein & Test, 1980).

Quantitative methods dominate the ACT literature and have contributed to the model being championed as an evidence-based practice (Drake & Bond, 2015). The ACT model has been the focus of a large number of randomized controlled trials (RCTs), and it has been referred to as the most highly researched topic in community psychiatry (Cuddeback & Morrissey, 2011; Morrissey et al., 2007). However, when reviewing this quantitative literature, it is difficult to get any sense of how ACT teams actually work, and the emerging picture is often clinical, decontextualized, and focused on positivist outcomes rather than processes and experiences. The overall picture that arises from quantitative research is that ACT is a recipe for delivering mental health services in any urban context, and that following this recipe rigidly will result in reduced hospitalization rates for consumers with mental illness who have high use of such services.

While the extant literature on ACT is robust, there is still relatively little qualitative research on the topic. This is despite qualitative methods being particularly well suited to providing in-depth, nuanced descriptions and interpretations of the inner workings of these teams within the contexts of the systems in which they operate. Through choosing qualitative methods for this project, I have intended to capture the complexities of human motivations, thoughts, and actions within the police-embedded ACT model as well as to illuminate some of the environmental factors and structural forces that contribute to shaping these. Qualitative methods not only have allowed me to describe “what is

happening” within the police-embedded ACT model, they have also supported me to examine “why” and to embed these insights within a sociopolitical and historical context.

1.2. Geographic Context of This Research

The location of data collection for this research was an urban setting in the Canadian province of British Columbia (BC). The name of this municipality has been masked to increase the level of confidentiality offered to participants and to focus attention on the phenomenon of embedding officers within the ACT model, rather than the setting. Although the exact location of data collection has been concealed, it is important for readers to understand the general environmental context from which police-embedded ACT emerged in this Canadian province. I will therefore provide a brief synopsis of key events that have contributed to the development and expansion of the police-embedded ACT model in BC.

Although embedding police officers in ACT is a newly emerging phenomenon, collaboration between municipal police departments and mental health services in BC is not. For example, BC municipalities have implemented emergency mental health assessment partnerships with police, such as the Car 87 program in Vancouver (Thompson, 2010), Car 67 in Surrey (Brink et al., 2011), Car 60 in Prince George (Fetinko, 2019), and Car 40 in Kamloops (Klassen, 2016). These crisis-response partnership programs have existed for decades, with the oldest (Car 87) having been operational for over 40 years (Wilson-Bates, 2008). These Car programs partner a police officer (either uniformed or plainclothes) with a mental health professional (nurse or social worker) from a local health authority. BC’s Car programs are primarily “crisis-response” models designed to react with immediacy to situations involving individuals with suspected mental health concerns that would otherwise result in a response by police officers alone. Although linked with the larger treatment system within which they are situated, these Car programs usually do not provide treatment and are instead focused on assessment and responding to urgent needs. I classify these crisis-response Car programs as categorically different from “proactive” treatment such as is seen in ACT with embedded police officers. I use the term proactive to emphasize characteristics such as planning, monitoring, treatment responsibility, and therapeutic relationships that occur with longitudinal “treatment” models such as ACT. However, proactive should not be confused with early intervention, or preventive services, given

that the ACT model is usually situated as an “end-of-the-line” service reserved for consumers with lengthy unsuccessful treatment histories (Bond & Drake, 2015).

The genesis of the police-embedded ACT model in BC lies in previous collaborations such as Car programs, and recent advocacy from municipal police departments and politicians identifying gaps in the mental health treatment system (Szkopek-Szkopowski, 2013; Thompson, 2010; Wilson-Bates, 2008). In the mid-2000s, the Vancouver Police Department (VPD) began releasing reports emphasizing that BC’s most densely populated city was experiencing a mental health crisis, that a high number of “emotionally disturbed persons” calls were taxing police resources beyond capacity, and that this situation was resulting in an unnecessary criminal justice response to people with mental illness (Szkopek-Szkopowski, 2013; Thompson, 2010; Wilson-Bates, 2008). Similar advocacy in the BC municipality of Victoria contributed to the emergence in 2007 of a collaborative relationship between the Victoria Police Department, the local health authority, the Ministry of Social Development, Community Corrections (probation), and the local drug treatment court, through a program known as the Victoria Integrated Community Outreach Team (VICOT) (Costigan & Woodin, 2018; Victoria Police Department, 2017; Thompson, 2010). VICOT appears to be one of the earliest documented proactive treatment collaborations between policing and mental health treatment in Canada and likely contributed to the creation of a police-embedded ACT model in several BC municipalities (Costigan & Woodin, 2018; Thompson, 2010; Victoria Police Department, 2017). For example, VICOT was specifically identified by the VPD in a series of internally generated reports as a positive collaborative treatment model that could be modified for the Vancouver context through use of the ACT model (Szkopek-Szkopowski, 2013; Thompson, 2010; Wilson-Bates, 2008). Victoria followed Vancouver’s lead in creating police-embedded ACT with an expansion of their partnership with VICOT to provide officer support to four police-embedded ACT teams (Costigan & Woodin, 2018). Other municipalities in BC, such as Surrey, have subsequently implemented ACT teams with embedded police officers or have added officers to existing ACT teams (Saltman, 2019), and appetite for this treatment model appears to be strong.

Upon their creation, BC’s police-embedded ACT teams quickly reached capacity, and the intake of new consumers slowed (Szkopek-Szkopowski, 2013). Police advocacy drew attention to this as a gap in care because consumers they identified as needing

ACT could no longer be enrolled. Further police advocacy led to the emergence of other short-term treatment models with embedded police officers as a potential solution. The resulting short-term treatment teams with embedded officers were conceptualized as being able to bridge the gaps and funnel consumers to police-embedded ACT teams once capacity allowed (Szkopek-Szkopowski, 2013; Thompson, 2010). In order to promote confidentiality and mask the exact location of this research, the pseudonym Assertive Short-term Program (ASP) has been used to identify the short-term treatment team in the setting where data were collected. Such programs are important because they can be contrasted with the police-embedded ACT model which is the focus of this research. While the ACT model (without embedded police officers) has been well defined and extensively researched, the treatment model used by these ASP teams has not. Because the ASP treatment model is unstandardized, virtually undocumented, and unevaluated, it would be difficult to separate experiences associated with the embedding of officers from the treatment model itself or to link findings with a body of existing literature. In conceptualizing this research topic, I recognized that the choice to use an ACT model in some BC jurisdictions provided an anchor point from which to make meaning about how the phenomenon of police collaboration with treatment shapes the experiences of the people directly involved in it. In addition, it facilitated the linking of my findings with previous ACT research.

To summarize, collaborations between police and mental health services are not new in the province of BC, with crisis-response models having existed for over 40 years. However, the emergence of proactive collaborations focusing on longitudinal treatment is a new phenomenon arising out of advocacy from municipal police forces. Although there has been considerable appetite in BC to create and expand police collaborations with mental health treatment, it is important to emphasize that emerging models with embedded police officers are virtually undocumented and unevaluated, meaning their short-term and long-term implications are largely speculative. However, the choice of using an ACT model for some of these collaborative treatment teams presented a unique opportunity for my research and has allowed me to situate findings within an extensive body of existing research.

1.3. Positioning Myself as a Researcher

I acknowledge that this research is shaped by the beliefs and biases that have formed through the accumulation of my life experiences and the intersecting social locations that form my identity. I am a middle-aged, cis-gendered, white male living on unceded First Nations territory in a first-world country. The privileges I hold have been influenced by Canadian society's prioritization of these attributes at this point in history. I acknowledge that the power I hold, and my desire to analyze potential power imbalances through this research, are based on this social location as well as my identities as a researcher and as a clinician in the mental health field. My beliefs, biases, and privileges have influenced the formation of my world view, the lens through which I approached and conducted this research.

I identify as a having close friends and family members who have battled with mental illness and substance use, and these experiences have informed my belief that there are profound gaps in our systems of treatment and care. These personal experiences motivate me to work and conduct research in the mental health field, and they shape my critical view of the current state of related policies and practices. I hold the professional designation of Registered Clinical Social Worker in the province of BC and have experience working with individuals who have been profoundly marginalized by our society. I believe that I was drawn to clinical practice and research in the mental health field through a desire, in the colloquial phrase, to "make things better" within our mental health system. My clinical experiences have included working with people experiencing mental illness in different settings, including the criminal justice system (institutional and community) and psychiatry (hospital and community). This has included previous work with ACT teams as well as in programs such as early psychosis intervention and acute home-based treatment. At the time I began writing this dissertation, I was also the first social worker ever to have worked in the Car 87 partnership program between mental health treatment services and the VPD. Although this dissertation takes a critical stance in analyzing the embedding of officers within an ACT model, this should not be assumed to indicate a critical view of police in general. In fact, it was through a meeting with a senior police officer that I solidified my early conceptualization of this research topic. That officer's advice to me as I was thinking

about entering this PhD program was to research the embedding of police officers in the ACT model because “no one” had done so before.

1.4. Theoretical Positioning of the Researcher

In addition to the social positioning that contributes to my world view, my clinical work and research are theoretically informed by postmodernism. My academic journey has resulted in exposure to a number of theoretical orientations, and of these, postmodernism has felt most congruent with my experiences, existing belief system, and biases. Elements of postmodern theory have provided me with an organizing framework through which to make sense of the systems within which I have worked, their implicit and explicit purposes, and how these shaped my experiences and actions. Although my intention has been for this project to have an applied focus, acknowledging this theoretical lens is important because it contributes to how I understand and make meaning of social phenomena and has informed my analysis and the conclusions I have drawn (Maxwell, 2012).

I was first exposed to postmodern theory during my undergraduate degree in Criminology but did not explore its concepts thoroughly until embarking on my Master of Social Work (MSW) degree. It was during my MSW that I had the time, support, and guidance to gain a more in-depth understanding of the work of postmodern philosopher and theorist Michel Foucault. His extensive focus on the constructs and discourses surrounding “madness,” criminality, and modern society’s responses to them contributed to my understanding of the systems I worked within and informed my conceptualization of this research project. The police-embedded ACT model, with its blending of psychiatric treatment and law enforcement resources, benefits from this theoretical lens because of postmodernism’s focus on issues such as power, social control, and the policing of differences in contemporary society.

Foucault wrote extensively about the concept of power and how it is expressed in modern society through discourses shaped by social structures and state mechanisms. Foucault examined how power is exercised over individuals and groups of people through the emergence of modern science and its systems of classification (Foucault, 1987; Madigan, 2011). Scientific classification promotes the objectification of people into “things” such as clusters of attributes or symptoms that totalize individuals through labels

of difference (e.g., “the schizophrenic” or “the criminal”) (Foucault, 1987). Foucault focused a critical perspective on the modern criminal justice system and psychiatry, and his work stressed similarities between those systems as state-sanctioned means of controlling and exerting power over citizens and maintaining order in society (Iopoulos, 2013; Madigan, 2011). Postmodernists use the term “dominant discourses” to explain how ways of knowing and understanding derived from scientific classification have been privileged to the point of being considered scientific truths. Although other ways of knowing (alternative discourses) about the same phenomenon exist, they become subjugated because of the status and power bestowed upon elite members of society who are empowered to classify others (Madigan, 2011).

Foucault wrote about the emergence of the modern urban state, which supplanted a feudal system of power that had relied upon physical force to control its population, such as through the military or police (Foucault, 1987; Madigan, 2011). Associated changes in the rise of modernity included the emergence of scientific thought and its eclipsing of religion in explaining events, as well as a shift from agricultural and rural existence to urbanization and mechanization (Bryson, personal communication, September 13, 2012). With these changes, and the corresponding population explosion, the modern nation state required mechanisms other than physical force to control the population, maintain order, and permit a small number of elites to retain control of society (Madigan, 2011). In other words, because physical forms of power were less effective for controlling large numbers of people, more subtle but pervasive forms became necessary. In the new world order of the modern urban state, power could be exercised through mechanisms that created implicit and explicit norms of conduct and normalcy within society (Bryson, personal communication, September 13, 2012). Foucault wrote about three ways in which power and control could be exerted by a small number of elite citizens over the larger society within these newly emerged nation states: dividing practices, scientific classification, and normalizing judgement (Bryson, personal communication, September 13, 2012; Madigan, 2011; White, 2007).

Foucault described dividing practices as both social and spatial (Bryson, personal communication, September 13, 2012; Madigan, 2011). They are social in that a grouping of people who differ from the norm can be formally classified into categories emphasizing this difference and facilitating their objectification and dehumanization (Madigan, 2011). For example, a person with symptoms of psychosis meeting the

diagnostic criteria for schizophrenia can be classified and labelled as “a schizophrenic” or “the schizophrenic” by another individual with the state-sanctioned power and authority to diagnose psychiatric conditions. Language choices such as this totalize the individual through a category of disorder rather than acknowledging them as a person first, experiencing symptoms that someone else has grouped together to form a diagnosis. Foucault noted that dividing practices are justified through science (or pseudoscience) and the power that society gives to scientific claims (discourses) (Iopoulos, 2013; Madigan, 2011). Foucault showed that at different stages of history, scientific universal truths pertaining to human social life have been held as privileged to certain professions (e.g., clergy, psychiatrists, scientists). Through this privileged status, these scientific classifications have been able to specify social norms, which in turn have become mechanisms of social control for society at large through a process called normalizing judgement (Madigan, 2011). Normalizing judgement describes how the strength bestowed on systems of scientific classification encourages people to internalize definitions of normality and abnormality and to measure (or self-police) their own thoughts and actions as well as to judge (and police) those of others (Bryson, personal communication, September 13, 2012; White, 2007). State control and power over the population can therefore be maintained with fewer physical mechanisms of control (such as through the military or police officers) because the population will police itself.

Dividing practices are also spatial in that once people are identified as different (often through means of scientific classification), they can be physically separated from society (Madigan, 2011). Such physical separation includes the use of structures such as jails and psychiatric institutions, often constructed in isolated locations away from more densely populated areas. In the more recent post-deinstitutionalization era, which has seen the outcomes of closing centralized psychiatric hospitals, Foucault’s conceptualization of dividing practices has been extended to marginalized neighbourhoods. For example, Wacquant (2009) theorized that marginalized neighbourhoods, often totalized and labelled as slums or ghettos, become epicentres of marginalization, where narratives of delinquency justify enhanced scrutiny of residents by state agencies such as the police (Collins et al., 2016; McNeil et al., 2015, 2016). Stigma associated with these physical spaces can also brand residents with a metaphorical blemish justifying unequal treatment, surveillance, and marginalization,

within the geographic boundaries of that neighbourhood but also when they venture beyond into more affluent spaces (Collins et al., 2016; Cummins, 2016; McNeil et al., 2015, 2016; Wacquant, 2009).

Being exposed to postmodern theory has provided me with a lens through which to make sense of the systems within which I began working (criminal justice, psychiatric, social welfare). Drawing on postmodernism has also provided me with a theoretical foundation whereby to better understand the phenomenon of police-embedded ACT, with its blending of psychiatric treatment and law enforcement resources. This theoretical base offers a way of understanding larger social forces that have contributed to the emergence of this treatment model, its growth, and how success is being measured and portrayed in the BC context. This theoretical base also provides a lens through which to understand how power is expressed, exercised, and understood by participants in relation to their experiences of police-embedded ACT.

1.5. Conclusion

The overall goal of this research is to explore how the phenomenon of embedding police officers within the ACT model shapes experiences of service delivery and health outcomes. Although crisis-response collaborations between policing and mental health services have existed in BC for over 40 years, proactive treatment collaborations are an emergent phenomenon that have yet to receive rigorous evaluation. Despite this lack of scrutiny, appetite for the police-embedded ACT model appears to be strong, and it has quickly spread across several BC municipalities. Because the ACT model is one of the most well-researched topics in community mental health treatment, it offers a well-described and understood treatment model through which this collaboration between mental health services and policing can be analyzed. The goal of this research is to begin exploring this model and how it shapes treatment experiences and health outcomes, through qualitative methods informed by grounded theory ethnography.

I have structured this thesis as several chapters, including this introduction, a literature review focused on the ACT model, a chapter describing the methods and methodology informing this research, three standalone manuscript chapters presenting my findings, and a concluding chapter. The three manuscript chapters are intended to

stand independently and will be modified for submission to peer-reviewed journals. Because of this chosen format, there is some repetition between chapters. The manuscript chapters present three major themes focusing on experiences related to (i) coercion, (ii) housing and homelessness, and (iii) flow and discharge in a police-embedded ACT model. Although my overarching research question asked how embedding police officers in the ACT model shapes treatment experiences and health-related outcomes, my findings showed that embedded police officers were not always central to emergent themes. Consistent with the inductive nature and the social constructivist underpinnings of grounded theory ethnography, I have presented dominant themes irrespective of the explicit centrality of embedded police officers. I feel that this approach is justified by my methods, and because my results showed that the physical presence of the embedded officers was not necessary for them to have an impact on episodes of service delivery; the potential that they *could* be present existed in every instance of treatment engagement between consumers and service providers. Through a postmodern analysis, I assert that the power of these officers as state representatives of enforcement and social control was transferred to service providers in every episode of care, irrespective of the physical presence of these officers.

The findings in this dissertation present descriptive detail of the phenomenon of embedding police officers in an ACT model, through the experiences and themes that my participants emphasized. Although I believe that all research is necessarily influenced by the lens of the person conducting it, I have used a data-near approach to present my findings, which facilitates readers in drawing their own interpretations and conclusions. As I consider my findings, I am left with more questions than answers. I view this as a strength of my research, as it points to areas for future inquiry and acknowledges the multiple discourses that exist about the phenomenon of police-embedded ACT.

Chapter 2. Literature Review

2.1 Introduction

Although the emergence of ACT teams with embedded police officers is a relatively new phenomenon, the ACT model itself has existed for decades and has a strong research base. Because the ACT model has been extensively described and analyzed, it provides a foundation through which the collaboration between policing and mental health services in my research setting can be viewed and understood. It is therefore important for readers to have an understanding of what the ACT model is, why it was created, what it does, and who it serves. This literature review chapter will provide an overview of these features and help to situate my research, its findings, and my conclusions.

2.2 Precursors to the Emergence of ACT

The process of deinstitutionalization is often cited as the genesis of the ACT model (Bond et al., 2001; Mueser et al., 1998). Deinstitutionalization usually refers to a phenomenon whereby large psychiatric hospitals were closed, and discharged consumers were transferred to some form of community-based treatment (Brodwin, 2008, 2011; Markowitz, 2006). In the province of BC, deinstitutionalization occurred when the centralized psychiatric institution known as “Riverview Hospital” began downsizing in the 1980s and ultimately closed its doors in 2012 (Davis, 2006). Research has shown that the community-based treatments and acute hospital settings in existence when the deinstitutionalization phenomenon began were ill equipped to provide care for this patient population (Chow & Priebe, 2013; Davis, 2006). The result for many discharged consumers was a revolving-door phenomenon of emergency room presentations and short-term psychiatric hospitalizations; this proved expensive for the government (Brodwin, 2011). The deinstitutionalization phenomenon is highly complex but is often attributed to several broad forces, including the advent of pharmacological interventions for psychotic illnesses, a social movement critical of lifelong institutional care, the emergence of the modern welfare state, and the growth of neoliberalism.

These forces combined to create a context within which many long-term psychiatric institutions were closed, including BC's Riverview Hospital.

Psychiatric deinstitutionalization in North America is often correlated with the advent and mass marketing of first-generation neuroleptic (antipsychotic) medications (Baillargeon et al., 2009). Although associated with stigmatizing side effects (Nordén et al., 2012; Pettersen et al., 2013), these early antipsychotic medications offered the possibility of community-based treatment for people who were previously cared for primarily through lifelong institutionalization (Chow & Priebe, 2013). However, consumer adherence to the neuroleptics has been low, contributing to the undertreatment of mental illness in community settings and the increased use of urgent hospital resources (Schöttle et al., 2013).

Also corresponding with the time period of deinstitutionalization was a growing movement to increase the use of client- and family-centred models of care (Bond et al., 2001; Brodwin, 2008; Davis, 2002; Watts & Priebe, 2002). Coupled with this was a changing moral discourse that critiqued institutional care as degrading and inhumane (Brodwin, 2008), and emerging theories such as postmodernism that categorized institutions as mechanisms of social control and expressions of state power (Boyd & Kerr, 2015; Butler & Tregaskis, 2007; Gutray & Morrow, 2013; Mladenov, 2015; Madigan, 2011; Noble, 2004). The movement to deinstitutionalize psychiatric hospitals should also be conceptualized within a broader social context that led to a paradigm shift towards community integration as an ethos of care (Boyd & Kerr, 2015; Brodwin, 2008, 2011). For example, the time period corresponding to psychiatric deinstitutionalization in North America saw movements toward community care and treatment for the elderly and for individuals with developmental, physical, and intellectual disabilities, and even a vast expansion of criminal justice system community-supervision options such as probation and parole as alternatives to incarceration (Estes & Harrington, 1981; Lemay, 2009; Mladenov, 2015; Vanstone, 2008).

Two other important but seemingly contradictory forces are important to consider in relation to the deinstitutionalization process in North America and the emergence of the ACT model: the rise of the welfare state and the strengthening discourses of neoliberalism. The term welfare state refers to a collection of government-administered income security programs implemented to provide a social safety net for citizens (Hick,

2007). Social assistance (welfare), Old Age Security, Employment Insurance and Workers' Compensation benefits are examples of income-security programs that form part of Canada's welfare state (Hick, 2007). The welfare state can also be considered more broadly to include programs and services peripheral to income security, such as social housing (as well as rent subsidies and rent control), subsidized medical services, and food security (Hick, 2007). The advent of these programs created the possibility that formerly institutionalized consumers could survive financially in community settings even if they were unable to participate in the workforce. As the welfare state emerged, the financial implications of implementing and maintaining these programs led governments to consider cost reductions, such as minimizing expenditures through closing most long-term psychiatric hospital beds (Chow & Priebe, 2013). However, financial savings from deinstitutionalization often dispersed to service a variety of social programs in the welfare state rather than being transferred specifically to community mental health treatment (Hick, 2007; Markowitz, 2006; Schneider, 2010). This left treatment systems chronically underfunded and unable to meet the demands of the most complex clientele discharged from psychiatric institutions (Baillargeon et al., 2009; Kinsler & Saxman, 2007; Markowitz, 2006; Schneider, 2010).

The rise of neoliberalism has also contributed to the deinstitutionalization process (Chow & Priebe, 2013; Morrissey et al., 2007). Neoliberalism promotes the privatization of government (public) functions and resources and the deregulation of economic markets (Mladenov, 2015). Neoliberal discourses foster an ethos of personal responsibility and freedom and call for the minimization or elimination of government and its administration of social safety mechanisms (Hick, 2007; Mladenov, 2015). As such, neoliberalism supported the closures of government-run psychiatric institutions in favour of more independent living in the community, where individuals and their families would be responsible for their own care. Although neoliberalism and the rise of the welfare state both supported the closure of large psychiatric hospitals, they diverged with regards to their positioning on government responsibility for care in the community for discharged consumers. Neoliberalism's focus on personal responsibility and a minimization of government social safety mechanisms justified a retraction of the welfare state and the programs that would support deinstitutionalized consumers. It can be argued that the deinstitutionalization process coupled with neoliberal claw-backs to the welfare state have contributed to the proliferation of social and economic

marginalization, disengagement from community treatment, and high use of urgent healthcare resources for many consumers with severe mental illness (Markowitz, 2006).

2.3 What is ACT?

The origins of ACT can be found in high emergency service use and readmission rates back to hospital for newly deinstitutionalized consumers. This “revolving door” phenomenon motivated an initiative by researchers in the late 1960s at the Mendota Mental Health Institute in the United States who sought to offer consumers training and skill development (often referred to as rehabilitation) within a hospital setting (Dixon, 2000; Lofthus et al., 2018). These researchers found that it was difficult to mimic the environmental context of community settings inside a hospital and, in a radical departure from conventional practice of that time, turned to community-based rehabilitation (Bond & Drake, 2015; Dixon, 2000; Marx et al., 1973). They hypothesized that an intensive level of treatment provided through outreach into the community could deliver improved rehabilitation outcomes, and that success would be evidenced through financial savings from reduced rehospitalization rates as well as improved symptomology and quality of life for consumers (Bond & Drake, 2015; Dixon, 2000). The pilot project that they developed, called the “Total In-Community Treatment Group,” was the precursor to the “Training in Community Living” program that later became known as the Program of Assertive Community Treatment (PACT) and then ACT (Aagaard et al., 2016; Dixon, 2000).

The economic cost of building and maintaining ACT teams is substantial, and such services are usually prioritized for consumers most in need and with whom the model has proved most efficacious (Cuddeback et al., 2006; Horvitz-Lennon et al., 2009; Latimer, 1999, 2005; Salkever et al., 1999). Over time, positive research results have led to uptake of the ACT model in different settings across North America (Bond & Drake, 2015). During this growth period, a variety of what researchers have retrospectively identified as ACT-like and ACT-lite programs emerged (Killaspy et al., 2009; Rollins et al., 2017). Program modifications such as these likely occurred because healthcare systems sought to minimize costs associated with the ACT model through changing aspects of service delivery (such as increasing the number of enrolled consumers per team or reducing operational hours) (Chen & Herman, 2012; Morrissey et al., 2007). Although now identified as ACT-like and ACT-lite, such programs were previously

lumped in with all ACT research, and mixed results called into question the entire ACT model (Killaspy et al., 2009; Rollins et al., 2017). Researchers identified the heterogeneity amongst ACT team compositions and processes at that time as problematic and sought tools to measure and standardize the model in order to reduce confounding variables and increase the credibility of research findings. The result was the development of fidelity measurement tools, which have supported the standardization of the ACT model and contributed to its classification as an evidence-based intervention (Monroe-DeVita et al., 2012). The first widely used fidelity measurement tool was the Dartmouth Assertive Community Treatment Scale (DACTS), and it remains the premier tool for measuring structural and service-delivery aspects of ACT teams in comparison to a prototypical or “ideal” model (Monroe-DeVita et al., 2012; Teague et al., 1998). The DACTS has been embraced by health systems creating new ACT teams, including the province of BC, because it provides clear and well-organized guidance for implementing structural elements of the ACT model (Teague et al., 2012).

Utilizing the DACTS as a framework, high-fidelity ACT teams are required to maintain standards related to providing time-unlimited, round-the-clock services, operating with low clinician-to-client ratios (1:10 or less), utilizing shared clinician decision making, having multidisciplinary staffing, and providing services primarily through outreach (Bond & Drake, 2015; Cuddeback, et al., 2009; Morrissey et al., 2007; Teague et al., 1998). One of the hallmarks of ACT service delivery is the use of a team-based approach whereby service providers from different disciplines are able to problem solve and provide generic services that may not fall under their specialization. For example, a consumer being seen by a nurse on outreach for medication administration might also request assistance with finding employment. In such circumstances, the nurse is supported to address this consumer-identified goal but also to later link with a more specialized team member (a vocational therapist), who can provide further assistance and support. Higher fidelity as measured through the DACTS usually corresponds with superior outcomes in reducing hospital use and, to a lesser extent, improving psychiatric symptomology, quality of life, and housing stability (Bond & Drake, 2015; Bond et al., 2001; Calsyn et al., 2005; McGrew et al., 1995; McHugo et al., 1999; Latimer, 1999; Teague et al., 1998; Tschopp et al., 2011).

The levels of support and services delivered through ACT are intense, and the model has been referred to as a “hospital without walls” (Morrissey et al., 2007; Santos

et al., 1995). ACT teams are able to provide nearly the same level of pharmacological intervention as inpatient hospital staff because the service-delivery model supports daily dispensing of medication and ongoing monitoring of effects and potential side effects (Brodwin, 2011). ACT service delivery also involves holistic psychosocial interventions such as assistance with activities of daily living, budgeting, and recreation (Bond et al., 2001; Dixon, 2000; Killaspy et al., 2009; Wright-Berryman et al., 2011).

Although now standardized, the ACT model has evolved to service changing populations and treatment needs through the addition of interventions on top of elements required for classification as high-fidelity ACT. For example, interventions have been added to the ACT model to increase consumers' employability (Latimer, 2005), to treat concurrent substance use in addition to mental health symptoms (Drake et al., 1998; Tsai et al., 2009), and to reduce high levels of criminal justice system involvement (Kelly et al., 2017; Marquand et al., 2016, 2018). The overrepresentation of ACT consumers in criminal justice systems has been a particularly elusive treatment target for the ACT model. The police-embedded ACT model that is the focus of this research represents one of several unique modifications to ACT made in the hope of addressing this domain. However, for new treatment initiatives such as police-embedded ACT to survive long enough to receive critical evaluation, visions of efficacy and definitions of treatment success will likely need to shift beyond hospitalization reductions alone (Bond & Drake, 2015).

2.4 Criminal Justice Involvement and Mental Illness

The impacts of deinstitutionalization are seen not only as causal factors in the revolving-door phenomenon of repeat hospitalizations, but also as precipitating events resulting in increased criminal justice system involvement for individuals with severe mental illness, as both victims and offenders (Beach et al., 2013; Bond & Drake, 2015; Boyd & Kerr, 2015; Erickson et al., 2009; Morgan et al., 2012; Schneider, 2010; Smith et al., 2010; Wolff et al., 2013). The scope of criminal justice involvement for individuals with mental illness has been recognized as problematic across Canada and internationally (Baillargeon et al., 2009; Cotton & Coleman, 2010; Fisher et al., 2006; Fujii et al., 2014; Markowitz, 2006; Morrissey et al., 2007). A report released by the Mental Health Commission of Canada states that 40% of people with mental illness have been arrested during their lifetime (Brink et al., 2011). People with mental illness in

Canada are also overrepresented in stun gun incidents, police-involved shootings, and the use of deadly force (Brink et al., 2011). In the United States, the scope of comorbid criminal justice involvement is extreme, with an estimated one million individuals with mental illness incarcerated annually (Morrissey et al., 2007). In that country, people with mental illness are now more likely to be incarcerated than hospitalized, and it has been argued that jails have replaced hospitals as the revolving door for people with mental illness (Morrissey et al., 2007). The term “trans-institutionalization” has been used to describe this process whereby one institution (jail) replaces another (psychiatric hospital) (Markowitz, 2006; Prins, 2011). Despite these alarming criminal justice statistics, described by Baillargeon and colleagues (2009) as a “public health crisis” (p. 103), there is limited access to evidence-based practices for criminally involved individuals with mental illness (Cuddeback et al., 2009).

Reasons for this criminal justice system overrepresentation are complex, and the deinstitutionalization of psychiatric hospitals, and resultant gaps in care, do not fully explain the phenomenon (Markowitz, 2006). Other factors contributing to this overrepresentation include the stigma and structural marginalization faced by individuals with severe mental illness, resulting from inadequate financial, social, and housing supports (Hick, 2007; Markowitz, 2006; Skeem et al., 2011). These factors can contribute to both increased levels of police contact due to visibility, as well as survival-based offending to acquire basic needs such as food and shelter (Boyd & Kerr, 2015; Elwood et al., 2012). It is also important to consider impacts of the American-led “War on Drugs” and its promotion of incarceration as a response to people who use drugs, an approach that has spread around the world (Alexander, 1990; Baillargeon et al., 2009). The high levels of substance use disorders concurrent with severe mental illness (Bahorik et al., 2013; Swartz & Lurigio, 2007) result in this drug enforcement policy disproportionately impacting ACT consumers (Baillargeon et al., 2009; Greenberg et al., 2011). Discretion also has a role in this criminal justice system overrepresentation (Markowitz, 2006), and individuals with mental illness are more likely to be arrested by police, are more often denied bail and detained pre-trial, and will serve longer sentences of incarceration compared to the general population (Cusack et al., 2010).

Researchers have identified a lack of evidence-based treatment interventions that can effectively address criminal justice system overrepresentation for people with severe mental illness (Cuddeback et al., 2009). Although efforts have been made to

assess the core ACT model as a mechanism to address this overrepresentation (Cuddeback et al., 2009; Cusack et al., 2010; Erickson, et al., 2009; Lamberti et al., 2004, 2011), research has shown it to be largely ineffective in this treatment domain (Bond et al., 2001). Researchers have therefore attempted to modify the ACT model towards specifically targeting criminal justice outcomes, and one such variation is known as Forensic Assertive Community Treatment (ForACT) (Baillargeon et al., 2009). Lamberti and colleagues (2004) provide guidance for distinguishing ForACT from ACT, including that the former programs aim to prevent arrest and incarceration, that all consumers have criminal justice histories, that most referrals come from the criminal justice system, and that the teams have access to supervised residential substance use treatment.

While over 40 years of research into traditional ACT has established links between model fidelity and positive results, this is not the case with ForACT (Cuddeback et al., 2009). Key ingredients of successful ForACT teams have yet to be established, and practices added to address criminogenic outcomes have far outpaced research to evaluate their efficacy (Cuddeback et al., 2009). There is currently no standardization of program staffing, training, or practices for teams that self-identify as ForACT (Cuddeback & Morrissey, 2011; Cuddeback et al., 2009; Morrissey et al., 2007), and many ForACT teams fall short of ACT fidelity standards and appear to be more “ACT-lite” than ACT (Lamberti et al., 2004; Morrissey et al., 2007). Some research on ForACT has also found that while these teams may be able to impact criminal justice outcomes, this likely comes at the expense of increasing hospitalization rates for consumers (Marquant et al., 2018).

Although the police-embedded ACT model that is the focus of my research exhibits some elements of ForACT, the lack of consensus as to what definitively characterizes ForACT makes it difficult to ascertain whether police-embedded ACT should be included within this grouping. Given this ambiguity, and the fact that the administrators of these teams make no claim to be ForACT teams, I have chosen to categorize them simply as ACT teams with embedded police officers. Although a strength of this research was its independence from the ACT teams being studied, this also precluded a comprehensive assessment of whether these teams actually met the criteria for high-fidelity ACT. A fidelity assessment would require intensive review of private healthcare records and unfettered interviews with consumers and service

providers. Such access was not available to me as an external researcher, and I therefore relied on these ACT teams' internal assessment that they met the criteria for classification as high-fidelity ACT (Anonymous, personal communication, August 10, 2016).

2.5 Who Are ACT Consumers?

I have chosen to use the term “consumer” to identify people receiving services from ACT teams. Although I do so with the intention of being respectful, I acknowledge that this term is not without controversy and assert that a full exploration of this issue would be a thesis in and of itself. A variety of terms, such as client, patient, survivor, person with lived experience, and consumer, have all been used to describe people with mental illness, and all have been critiqued (Costa et al., 2019; Radden, 2012; Torrey, 2011). There was also a great deal of variation in the terms my consumer participants used to identify themselves and the terms used by service providers to identify consumers, which included client, consumer, patient, and prisoner. My intention in choosing the word consumer has been to provide readers with a concise and consistent identifier through which to understand the content of this research. There was also a great deal of variation in the terms my service provider participants used to identify themselves and the terms used by consumers to identify ACT service providers. These included connection with specific professions (nurse, social worker, shrink, cop), generic terms (clinician, service provider, worker), and more critical identifiers such as “mental police”. As with the term consumer, my choice of using the term service provider has been to provide readers with a consistent identifier for readers.

It is important for readers to have an understanding of the typical characteristics ACT consumers and how this population has changed since the ACT model first emerged. While the ACT model was originally designed for a population who had been institutionalized, a growing number of contemporary ACT consumers were born after deinstitutionalization unfolded and have never experienced institutional psychiatric care in their treatment trajectories (Bond & Drake, 2015). Issues such as poverty, homelessness, substance use, and criminal justice involvement have become more prominent for ACT consumers with treatment pathways that have been based primarily in community settings (Bond & Drake, 2015; Cuddeback et al., 2006; Watts & Priebe, 2002).

ACT consumers, and people with severe mental illness in general, face a variety of structural forces that contribute to stigma and societal marginalization in community settings (Fisher & Drake, 2007; Gonzales et al., 2014; Mladenov, 2015; O'Campo et al., 2009). Some of this marginalization and stigma likely derives from the level of functional role impairment associated with some mental illnesses, such as schizophrenia, that prevent consumers from participating in the labour market or taking other meaningful roles in society (Angell, 2003; Dixon et al., 2010; Teague et al., 2012). Lower social functioning has also been linked with disengagement from psychiatric treatment services (Kreyenbuhl et al., 2009) and is an area targeted for intervention through ACT treatment (Dixon et al., 2010; Teague et al., 2012).

ACT consumers are often described as experiencing “severe” mental illness, which can be conceptualized as a specific subgrouping nested within the larger category of “serious and persistent” mental illness (Cuddeback & Morrissey, 2011; Morrissey et al., 2007; Rollins et al., 2010). Serious and persistent mental illness is often defined by diagnostic criteria alone, such as when a person experiences a clustering of symptoms that meet the criteria for a diagnosis of schizophrenia. Severe mental illness can be differentiated through its focus on the degree of impairment, or disability, that can occur, in addition to a diagnosed mental illness such as schizophrenia (Morrissey et al., 2007). Such impairment can be exhibited through features such as frequent hospitalizations, periods of homelessness, social and vocational impairment, criminal justice system involvement, or difficulty engaging with traditional community-based mental health treatment services (Lamberti et al., 2004; Morrissey et al., 2007; Salyers et al., 2013). In addition to its focus on reducing symptoms of mental illness, ACT treatment can target interventions in one or more of these dimensions of impairment, such as through vocational programs or housing assistance (Coldwell & Bender, 2007; Macias et al., 2006).

ACT consumers often rely on income-security and social-welfare programs because of their exclusion from the workforce, and in the Canadian context this results in poverty (Krupa et al., 2005; Micoli, 2005). Therefore, the impoverishment of ACT consumers should be considered a by-product of inadequate social assistance rates for persons with disabilities and deficiencies in the larger social safety net that should protect them (Fisher et al., 2006; Gomery, 1998; Gutray & Morrow, 2013; Morrissey et al., 2007; Wiktowicz, 2005). In this context poverty is an outcome of severe mental

illness and is also considered a potentially destabilizing force with regards to psychiatric symptomology (Gomory, 1998; Krupa et al., 2004; Markowitz, 2006). This can create a vicious downward spiral in which mental illness causes financial hardship, which then negatively impacts an individual's mental health, which in turn causes more economic marginalization.

ACT consumers, and individuals with severe mental illness in general, are also characterized by high rates of homelessness and housing instability (Coldwell & Bender, 2007; Stanhope & Dunn, 2011). While homelessness may be related to poverty, it can also be seen as a product of the gentrification of affordable housing, and failures in social policies to provide affordable housing to individuals with disabilities, including those with mental illness (Dixon et al., 2010; Fisher et al., 2006; Lloyd-Smith et al., 2010; Morrissey et al., 2007). While both poverty and homelessness can aggravate psychiatric symptomology, they should also be recognized as sometimes distinct from the etiology of mental illness. It has been cautioned that factors such as poverty and homelessness can result in the medicalization of "problems" associated with the previously described deficient social safety nets and misguided social policies (Angel & Bolden, 2015; Fisher & Drake, 2007; Skeem et al., 2011). Homelessness also creates a recognized visibility for persons with mental illness that has been attributed to increased negative police contact and overall criminal justice involvement, as well as compounding stigma and social marginalization (Markowitz, 2006).

Individuals with severe mental illness, and ACT consumers in particular, are also recognized for having high rates of concurrent substance use disorders (Drake et al., 2004; Mueser et al., 2006; Murthy & Chand, 2012). Although both epidemiological and clinical research have emphasized this comorbidity (Hasin & Kilcoyne, 2012; Pettersen et al., 2014), early ACT research found the model to be relatively ineffective at impacting this treatment domain (Morrissey et al., 2007). The clinical presentation of co-occurring substance abuse and severe mental illness, and questions of treatment efficacy for affected individuals, began emerging in the literature in the 1970s (Drake et al., 2004). Despite increased recognition of the scope of this problem since then, there has been an overall paucity of research focusing on effective treatments for concurrent disorders (Murthy & Chand, 2012). A possible reason is that individuals with concurrent disorders also have high rates of disengagement from traditional mental health services (Kreyenbuhl et al., 2009). Increasing recognition of the significance of this comorbidity

led in the 1980s and 1990s to an enhanced focus on adding evidence-based treatments targeting substance abuse to the ACT model (Bond & Drake, 2015; Drake et al., 2004). Such modifications have included adding addiction or concurrent disorders counsellors as well as transitioning ACT teams toward a model of “Integrated Dual Diagnosis Treatment” (Drake et al., 2004). Since the implementation of these modifications, ACT has produced more favorable substance use treatment outcomes, although overall efficacy in this domain remains mixed (Bond & Drake, 2015; Drake et al., 2004).

2.6 Conclusions

The ACT model is now over 40 years old and is considered the most well-studied community psychiatric intervention apart from medications. ACT was conceived of during a period of time when the locus of care shifted from institutions to communities. Gaps in care began emerging as systems struggled to find balance within this new paradigm of post-deinstitutionalized healthcare. The original ACT model was designed to assist consumers who did not thrive in this new environment and as a result disengaged from treatment, entering a revolving-door pattern of repeat hospitalizations and social marginalization. As the length of time increases since the deinstitutionalization process unfolded, there will be more consumers enrolled in ACT programs who have never set foot inside of a centralized psychiatric institution. The question that arises from this is whether ACT will be found to be as effective with this new cohort as it has been with consumers who experienced institutionalization.

Because the core ACT model has shown little efficacy in addressing high levels of criminal justice system involvement experienced by ACT consumers, modifications such as the ForACT model have emerged. However, to date there is little standardization in the ForACT model, and its efficacy in addressing both mental health and criminal justice outcomes is largely unknown. The police-embedded ACT model that is the focus of this research represents another modification that seeks to address outcomes in these two systems. However, similar to the ForACT model, there is a dearth of knowledge about how the embedding of police officers in an ACT model shapes treatment experiences or health-related outcomes. My research seeks to provide descriptive details about the experiences of consumers and service providers within a police-embedded ACT model, to begin addressing this knowledge gap.

Chapter 3. Research Approach

This chapter provides a detailed overview of my research approach and includes a description of the aims of this research, ethical considerations, and descriptive detail of my research methods, from data gathering through analysis. Given the manuscript-based style of this dissertation, further discussion of these topics will also follow in each of the separate chapters that detail my findings.

3.1. Research Aims

The overarching goal of this research has been to describe the phenomenon of embedding police officers within the ACT model and how this shapes the health outcomes and treatment experiences of service providers and consumers. The study objectives were to: (1) examine the experiences of service providers, including police officers, working on ACT teams with embedded police officers; (2) examine the experiences of consumers receiving services from ACT teams with embedded police officer; and (3) document and analyze the service delivery of police-embedded ACT teams through observational fieldwork.

3.2. Ethical Considerations

Ethical approval was obtained from SFU's Behavioural Research Ethics Board (2016s0022). This minimal risk ethics certificate covered observational fieldwork as well as in-depth qualitative interviews with service providers from police-embedded ACT teams in a BC urban setting.

The majority of the ACT service providers were current or former employees of a BC health authority, and operational research approval was obtained from that organization to facilitate recruitment. The police officers embedded in these ACT teams were employees of a municipal police force. I asserted in my SFU ethics application that operational approval should not be obtained from that police department because recruitment fell under the purview of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS2) provisions of Critical Inquiry (TCPS2; Article 3.6). That section states in part:

Where the goal of the research is to adopt a critical perspective with respect to an institution, organization or other group, the fact that the institution, organization or group under study may not endorse the research project should not be a bar to the research receiving ethics approval. Where social sciences or humanities researchers seek knowledge that critiques or challenges the policies and practices of institutions, governments, interest groups or corporations, researchers do not need to seek the organization's permission to proceed with the proposed research. (TCPS2; Article 3.6)

An amendment to an existing Providence Health Care (PHC) and University of British Columbia (UBC) ethics certificate held by my senior committee supervisor (Dr. Will Small) was also sought and obtained (H10-00838). This amendment facilitated the recruitment of potential participants with lived experience of receiving ACT services, through ongoing prospective cohort studies being conducted by the British Columbia Centre on Substance Use (BCCSU). I was added to that BCCSU certificate as a co-investigator to facilitate this amendment process and the approval of an interview guide. A harmonized SFU certificate (2014s0338) was also recognized by SFU ethics as associated with the independent ethics certificate obtained for this PhD research (2016s0022).

I have taken several precautions to increase the degree of confidentiality provided to participants. Obtaining informed consent from service providers was a verbal process, and no names were recorded. All service providers were given written copies of the informed consent document and asked to verbally consent to participating in an interview prior to commencing. This informed consent process was audio recorded and documented in transcripts. In keeping with the requirements of the PHC/UBC ethics certificate, which permitted the recruitment of ACT consumers, an informed consent document was used that required signatures from that grouping of participants. Consumer participants were offered a copy of this form and ethics-approved "information cards" that provided a brief plain-language summary of my study's conduct. The signed informed consent documents were placed in secure storage under the supervision of Dr. Small. Transcripts derived from interviews and field notes were all sanitized of personally identifying data. Audio recordings were erased after they were transcribed and the transcriptions had been checked for accuracy. Where feasible, reference to the specific geographic locations of data collection were also removed, and pseudonyms were used

to describe neighbourhoods, buildings, and people in an effort to enhance confidentiality for participants and to mask the specific locations of data collection.

3.3. Grounded Theory Ethnography

In this research, I theorize that how the inclusion of police officers in the ACT model shapes treatment experiences can best be illuminated through a data-near analysis of the experiences of individuals directly involved in the phenomenon. I have therefore turned to a form of qualitative research known as grounded theory ethnography to inform my research methods. Specifically, I have drawn from the work of Kathy Charmaz, who proposes a constructivist variant of grounded theory that incorporates focused ethnographic data collection (Charmaz, 2006, 2009).

Grounded theory ethnography combines elements of ethnography with grounded theory but is not simply an amalgamation of these two methods (Babchuk & Hitchcock, 2013). Key elements of grounded theory ethnography that differ from traditional grounded theory are a flexible interpretation of the constant comparative method, an embracing of social constructivism, where meaning is seen as co-constructed between researcher and participants, and a view of theory generation as descriptive rather than explanatory (Charmaz, 2006, 2009). Grounded theory ethnography also differs from “classic” ethnography because observational fieldwork concentrates on phenomena rather than settings, is briefer in duration, and extends across settings, and the overall scope of the research is more focused and less exploratory (Charmaz, 2006).

Some researchers have critiqued traditional grounded theory for evolving toward a positivist, inflexible, and prescriptive set of research procedures (Charmaz, 2006; 2009; Clarke, 2005). Through incorporating elements of social constructivism, Charmaz (2006, 2009) proposes a more malleable set of grounded theory methods that invite curiosity, imagination, and flexibility, as well as an acknowledgement that there is a plurality of meanings for any given phenomenon. Social constructivism supports that the meanings participants attribute to phenomena or processes are necessarily mediated by a lifetime of social interactions as well as the historical and cultural norms of the time period they live within (Chamaz, 2006; Creswell, 2018). Data generated through in-depth interviews are viewed as stories (discourses) about a phenomenon rather than as finite truths about what happened. A social constructivist lens therefore accepts that

alternative discourses necessarily exist about the same phenomenon (Creswell, 2018). Further, the research process is viewed as intertwining the researcher within this meaning making such that through the research process, the researcher co-constructs a discourse about a phenomenon with their participants (Charmaz, 2006; Taylor, 2018).

Charmaz (2006) breaks down the grounded theory ethnography research process into several steps but calls for flexibility in their implementation. These steps include data gathering, coding, memo writing, theoretical sampling, sorting and saturation, reconstructing theory, and writing drafts. I used these steps as a general guideline for conducting my research.

3.4. Data Collection

Data were gathered through 47 semi-structured qualitative interviews conducted with participants occupying two distinct positions: those who self-identified as service providers on police-embedded ACT teams (N = 23) and those who self-identified as having lived experience (consumers) of receiving services from police-embedded ACT teams (N = 24). Data collection also included focused ethnographic fieldwork consisting of observational data collection and informal interviews conducted in the field. The combination of all of these data collection methods provides a robust and well-rounded source of contextual details regarding how the embedding of police officers in the ACT model shapes treatment experiences for those directly experiencing this phenomenon.

Grounded theory ethnography suggests that ethnographic fieldwork should be focused on a phenomenon rather than on the setting itself (Babchuk & Hitchcock, 2013; Bamkin, 2016; Charmaz, 2006; Charmaz & Mitchell, 2001). Consistent with this, the observational fieldwork I conducted was focused both spatially and temporally. My fieldwork was geographically focused within a neighbourhood of a large urban centre in BC that is often characterized by the media through discourses emphasizing poverty, open drug use, and crime. In order to maximize confidentiality for participants, the name of this neighbourhood has been replaced in this dissertation with the pseudonym “The Block.” Although the police-embedded ACT teams being studied provide services to consumers who reside outside of The Block, early in-depth interviews suggested that the highest concentration of public interactions between service providers and consumers

would be in this neighbourhood. Therefore, observational fieldwork was conducted in public spaces of The Block, including streets, alleyways, parks, and community centres.

Permission was also sought, and received, from the Community Support Society (CSS)¹ to conduct observational fieldwork inside one of the buildings they operate within The Block neighbourhood. To increase the confidentiality offered to participants, the pseudonym “Met Community Building” will be used to describe this location. The Met Community Building has 39 supported “transitional” units (two-year term) and 100 “permanent” low-barrier housing suites. I emphasize the terms transitional and permanent due to the flexible interpretation of these terms as operationalized by CSS, such that their distinction has blurred to some degree. Observational fieldwork in the Met Community Building was primarily conducted in public spaces except when residents specifically invited me to accompany them to more private locations, such as their suites. Observational fieldwork within this building also facilitated theoretical sampling (Charmaz, 2006), whereby purposeful recruitment targeted residents based on their proximity to observed episodes of police-embedded ACT service delivery. Met Community Building residents and CSS staff were welcoming of me, but there were isolated instances where ACT staff members entering the building to deliver services seemed uncomfortable with my presence. For example, there were times when ACT staff members avoided eye contact, walked away, or even took the service elevator to avoid engaging. When I noticed such potential discomfort, I did not approach these staff members but instead withdrew from the situation.

Consistent with grounded theory ethnographic methods, my fieldwork was also temporally focused. Although high-fidelity ACT has 24-hour availability, the police-embedded variants that were the focus of this research have shorter working hours, with after-hours coverage provided by other programs. As data collection progressed, it became evident that the staffing schedules of these teams were most robust on weekdays from 09:00 to 17:00. These police-embedded ACT teams also conducted morning meetings (care-planning rounds), which decreased the likelihood of outreach into the community prior to 09:30. Given this schedule, the highest concentration of staffing to conduct outreach appointments clustered between Monday and Friday from 10:00 to 15:00. Therefore, I was able to conduct much of this observational fieldwork

¹ A pseudonym has been used for this non-profit to mask the location of this research.

through walking and waiting in busy public areas during these hours of concentrated ACT service delivery.

An important element of ethical research with clients who have experienced significant social and structural inequities is the development of a trusting and transparent relationship, with attempts to level researcher–participant hierarchies (Brear, 2018). I attempted to build transparent relationships through identifying myself using an ethics-approved verbal script during observational fieldwork. However, because much of this observational fieldwork was conducted in outside spaces where large numbers of people congregated (such as a public park or alley), it was not always realistic or possible to identify myself to the people I was observing. However, every time that I engaged in data collection through informal interviews, I first introduced myself, explained my role as a researcher, and obtained verbal consent, prior to proceeding with data collection. These informal interviews also allowed me to explain more about the intent of my study, and in some cases recruit (theoretically sample) potential participants for in-depth interviews. I had pre-planned to remove myself from any situation if asked during the course of conducting observational fieldwork. For almost all of the observational fieldwork, there was limited interest in what I was doing, and people appeared to become accustomed to my presence. There was only one occasion where a member of the public became upset at my presence, but this apparently was due to their perception that I was an undercover police officer. When I attempted to explain that this was not the case and identify myself as a researcher, that individual remained upset, so I simply left the area to defuse the situation. While walking away, I heard this individual yelling at another person nearby, expressing similar concerns about them.

I used a variety of data collection techniques during observational fieldwork and informal interviews. When feasible, I made shorthand notes in a journal, detailing observations of what I thought was happening, what I was feeling about it, and contextual details of the situation and setting. When taking field notes in the moment was not possible or may have been intrusive to those being observed, I waited until the observations were over to find a private location where I could record my notes either in writing or through voice memos. On one occasion, a resident of the Met Community Building asked to read what I was writing in the journal. I attempted to be transparent, explaining what types of things were being recorded and giving hypothetical examples. Raw data were not shared with that individual due to confidentiality boundaries, because

notes included observations about other individuals as well. That individual stated satisfaction with the response I gave. Data from the observational fieldwork and informal interviews were used to provide context for in-depth interview data as well as to inform the evolution of interview questions, ongoing recruitment, and analysis. These field notes also contributed to the memo writing that I undertook throughout the data gathering and analysis process. These memos assisted with the writing of draft manuscripts for the chapters of this thesis, and these processes were consistent with the grounded theory ethnography methods that inform my research (Babchuk & Hitchcock, 2013; Bamkin, 2016; Charmaz, 2006; Charmaz & Mitchell, 2001).

3.5. Description of Participants

The recruitment of participants for in-depth interviews occurred through a combination of targeted recruitment, snowball sampling, and peer-driven recruitment to target two specific populations: (1) Service providers currently or previously employed by ACT teams with embedded police officers and (2) people with present or past lived experience of receiving services from these teams (consumers). All individuals participating in this research were 19 years of age or older.

In completing the literature review for this research project, I found that most qualitative investigations have focused upon consumers categorized as “engaged” in services and “stable” in their recovery. I believe that this approach will necessarily exclude the perspectives of clients who are “more difficult to engage,” those who have disengaged completely, or those actively resisting services. This presents as a paradox of previous ACT research given that the treatment model itself is designed to reach the most difficult to engage consumers. In other words, the very population that ACT shows prowess in treating appears to have been largely excluded from qualitative research through these practices that favour consumers who are likely to be more engaged in services. In studies where methods are reported, recruitment for the majority of qualitative ACT research has often been directly through clinicians working on the teams being studied. This holds the potential to introduce bias by allowing clinicians to regulate who ends up in the participant sample. Such a recruitment strategy should also be expected to emphasize the experiences of the most successful ACT consumers, as well as those with the strongest and most positive relationships with service providers. In an attempt to reduce this bias and to welcome potentially unheard experiences, my

research did not set exclusion criteria requiring potential consumer participants to be psychiatrically stable or engaged in services. My research appears to be the first of its kind to actively recruit consumers entirely externally from their treatment teams, and the first to have inclusion criteria that allowed people with active psychotic symptoms to fully participate in interviews.

The decision to interview participants who were experiencing psychotic symptomology (such as thought disorder, delusional thought content, and hallucinations) did have consequences related to data collection and analysis. I took great care to ensure that participants experiencing psychotic symptoms were still able to understand the informed consent process prior to me initiating an interview. There were three potential participants who could not be interviewed because I assessed that they were unable to give informed consent. These individuals were provided with honoraria for their time despite not being interviewed. In addition to these three interviews that could not proceed, there was an additional participant who on a first attempt could not provide informed consent but at a later date was able to do so and was interviewed. I searched without success for literature to guide the conduct and analysis of interviews with participants experiencing psychosis. In the absence of such guidance, I decided to rely on clinical judgement and skills developed through working in the mental health field. No attempt was made to challenge delusional thoughts, and in almost all cases, participants could be guided back to topics pertinent to the study's aims. Content that was blatantly delusional was excluded from analysis, and in some cases transcript content that had neologisms (invented or nonsensical words or phrases) was also excluded if it made the content unintelligible. Consistent with my direct practice work with people experiencing psychosis, even the most bizarre delusions usually had an important core reality that could be teased out with skill and patience.

When possible, I used skills such as paraphrasing as well as theme and content summaries to ascertain whether I was understanding my participants and as a form of member checking. Although these skills were used to clarify stories shared by my participants, if one views research as the co-construction of knowledge between researcher and participants (Charmaz, 2006), decisions I made—such as what I asked, how I did so, and which points I sought clarification on—necessarily influenced discourses shared by participants. Rather than simply hearing the story of a phenomenon, I interjected into my participants' stories myself and the lens through

which I found meaning. Through this process, we combined their experiences, how they remembered and chose to relate them, and how I interpreted them into a co-constructed discourse about the phenomenon.

3.6. Service Provider Interviews

Service provider participants (N = 23) represented many different professions and roles. To maximize confidentiality for participants, I do not report the numbers in each profession/role. Participants self-identified as nurses, social workers, occupational therapists, police officers, physicians, peer support specialists, concurrent disorders counsellors, care coordinators, and clinical supervisors/coordinators. The age range of service provider participants was 31–63 (mean = 43 years). Fourteen participants identified as male and nine as female. Participants declared between two and 35 years of work experience in their chosen field (mean = 11.5 years) and between one and seven years of work on an ACT team (mean = 3 years). Some participants chose to include experience working on ACT teams in other jurisdictions in this latter category. Fourteen participants had graduate degrees as their highest level of education (inclusive of physicians), seven had bachelor's degree, and two had diplomas.

Service provider participants were recruited through a combination of targeted email sent through the health authority employing them (operational approval was obtained) and snowball sampling. Inclusion criteria necessitated that a potential participant had worked on an ACT team with embedded police officers for at least one year. This requirement was intended to recruit more experienced staff with a depth of knowledge to draw upon in interviews. Potential participants did not have to be current employees of a police-embedded ACT team so long as their total experience working with police-embedded ACT exceeded one year. Service provider interviews were conducted in a variety of locations that were convenient for them, including coffee shops, restaurants, offices, and my vehicle. The interviews were guided by an ethics-approved interview guide. However, I used an inductive approach and allowed participants to explore aspects of police-embedded ACT treatment that they felt were important, rather than forcing them to strictly adhere to my interview guide questions.

3.7. Consumer Interviews

Most consumer participants (N = 24) were recruited from within three ongoing BCCSU prospective cohort studies: the Vancouver Injection Drug Users Study (VIDUS), the At-Risk Youth Study (ARYS), and the AIDS Care Cohort to Evaluate Exposure to Survival Services (ACCESS). Details of the methodologies used in these prospective cohort studies have been described in depth by other researchers (see Strathdee et al., 1997; Wood et al., 2001). Prospective cohort participants have been recruited through snowball sampling, outreach, and self-referral. The ARYS cohort is composed of street-involved youths and was created to research a variety of factors influencing the health of this population. The VIDUS cohort is composed of HIV-negative adults who use drugs. The ACCESS cohort is composed of HIV-positive adults who use drugs (including VIDUS members who later tested positive for HIV). For data collection, all of these prospective cohort studies utilize interviewer-administered questionnaires, clinic visits and bloodwork, and qualitative interviews.

Dr. Will Small, my senior supervisor, facilitated the addition of items to the questionnaire administered at regular intervals to these three cohorts, with the intention of flagging potential participants for this ACT study. The questions remained on that data collection instrument for approximately three years. One question explicitly asked cohort members whether they were currently receiving services from police-embedded ACT. Unfortunately, the number of flagged participants this returned made it clear that there was a high number of false positives. Upon investigation, it appeared that research staff administering this question were using it as a “catch all” category for “other” services and then making notes beside for clarification; however, the notes could not be identified and separated out through the computer flagging system. This meant that paper copies of the questionnaires had to be individually reviewed by BCCSU research staff to ascertain whether the item had been flagged for the correct reason. Although this hand-picking reduced the number of potential participants, it still produced a large research pool that was likely indicative of false positives in the flagging system.

To reduce the number of potential participants and to increase specificity, I then devised an algorithm combining a number of instrument questions. Although this reduced the number of flagged individuals to a more manageable number, it was still in excess of what would be expected for ACT participants from within the BCCSU cohorts.

Therefore, I formulated a three-question screening tool and criteria for hand-picking flagged cohort members in collaboration with Dr. Small. This algorithm was then explained to and implemented by a small number of research staff working at two storefront offices (referred to as the VIDUS office and the ARYS office) and was consistent with approved recruitment methods used in previous BCCSU research. In brief, flagged cohort members who attended one of these two offices as drop-ins were asked the screening questions by a designated research staff member to determine their eligibility for my ACT study. Once potential participants were screened as meeting the eligibility requirements of this study, they were provided with a brief verbal synopsis of the study and a description of its conduct, then were asked whether they would be interested in participating.

Initially I set aside one day per week to be present at the VIDUS research office in order to build connections with other research staff and to facilitate the booking of interviews. While connections were built, and interest in this research grew, it became apparent that the individuals being invited to interviews had difficulty making set appointment times; the number of no-shows made it necessary to develop a different strategy. A new system was designed whereby when individuals who had difficulty making or keeping appointments “dropped in” to the office, research staff discreetly identified them. These potential participants were provided with a brief explanation of the study and asked whether they would be interested in participating in an in-depth interview. If they consented to proceed, then the research office staff member would contact me. If possible, I would attend the office within a given period of time (30 to 60 minutes) to interview that person on site. Even with this flexibility, there were instances where either interview space was unavailable or the participant was not able to wait. In such cases, research staff would seek consent from the potential participant for me to contact them directly and to meet with them at another location and time. This could include locations such as the participant’s residence or at an emergency shelter, a coffee shop, or a social service storefront in their neighbourhood. In a sense, the same outreach strategy fundamental to the ACT model also became a necessary component of my research.

I conducted 24 semi-structured interviews with ACT consumers, based on an ethics-approved interview guide. Although this interview guide was a starting place to inform interviews, I used an inductive approach and allowed participants to deviate from

my questions to explore aspects of police-embedded ACT treatment that they felt were important. Interviews lasted between 20 and 90 minutes. Honoraria of CAD 30 were offered as compensation for interviewees' time. Interviews were audio-recorded and later transcribed and imported into NVivo 12 qualitative software to facilitate analysis.

Out of a total of 24 participants with lived experience receiving services from ACT, 17 identified as male and seven as female. The age range was 25–62 (mean = 43 years). Thirteen participants self-identified as Caucasian, nine as Indigenous (respectfully inclusive of First Nations, Métis, and Inuit), and two as black. Of these interviewees, nine were recruited from VIDUS, two from ACCESS, and five from ARYS. Eight ACT consumers were interviewed who were not involved in the cohort research. Sixteen consumer participants resided in either private or public single room occupancy hotels (SROs). Three resided in emergency shelters, and three were unsheltered or living in absolute homelessness. One participant resided in “addiction housing” and another in a licensed care group home facility.

Participants were asked whether they had a mental health diagnosis, and if they had more than one, which one they thought was their primary diagnosis. Sixteen reported schizophrenia, four reported schizoaffective, one reported “psychosis,” two reported bipolar, and one reported depression and anxiety. It should be noted that most participants reporting a diagnosis of schizophrenia or schizoaffective disorder felt that it was a label imposed upon them and disagreed with this classification. Most participants also expressed a lack of knowledge around the diagnostic criteria of their assigned diagnosis and in some cases sought clarification from me on terms and diagnostic criteria. In such cases, I directed participants to an appropriate community resource or their treatment team for clarification. Almost all participants used stigmatizing discourses to describe primary psychotic illnesses such as schizophrenia and schizoaffective disorder, even if they shared that they had been labelled with that same diagnosis. For example, most participants who stated that they had been diagnosed with schizophrenia used stigmatizing language when describing others as “schizophrenics,” and differentiated themselves from “those people.”

Fifteen participants reported at least one hospitalization in the previous year (two of these were for primary care medical issues and not psychiatric reasons), and the length of hospital admission ranged from one to 90 days. All participants reported a

history of polysubstance use, and 22 reported current use of at least two substances. Fifteen participants acknowledged daily or more frequent substance use. Eighteen participants reported a history of intravenous drug use. The majority of participants currently using substances listed central nervous system stimulants as their current drug of choice, with 10 reporting crystal methamphetamine and three reporting rock cocaine (crack).

With regard to criminal justice contact, 16 reported having been arrested in the previous five years, and seven reported a period of incarceration in the same time period. (Being held in municipal police department cells was not included as a period of incarceration.) With regards to forensic psychiatric service involvement, seven participants reported having previously received services from Forensic Outpatient Services, and three reported at least one previous hospitalization in BC's Forensic Psychiatric Hospital. A high number of participants reported being involuntarily treated by their ACT teams. Nineteen participants reported that their care was mandated under the provisions of Extended Leave (community treatment orders) in BC's Mental Health Act. An additional three participants reported that in the previous two years, they had won Review Panel hearings to remove themselves from Extended Leave.

Consistent with the constant comparative method, analysis was ongoing during data collection, and recruitment of service providers and consumers was terminated only after data saturation was reached on major themes (Charmaz, 2006; Charmaz & Mitchell, 2001; Denzin & Lincoln, 2011). To reach data saturation, I employed a technique called theoretical sampling (Charmaz, 2006) by targeting recruitment and observational fieldwork towards elaborating on and refining themes. For example, although I began data collection with service provider interviews, I purposefully paused after several were completed because I felt that data from consumer interviews would be helpful in fleshing out emergent themes that would inform future service provider interviews. I also terminated service provider interviews and continued to recruit consumers in order to ensure that I had fully explored, tested, and refined emergent dominant themes. Another example of theoretical sampling was my decision to target residents within the Met Community Building for in-depth interview recruitment after observing several episodes of care that pointed to a theme related to potential coercion. This targeted recruitment was helpful because it facilitated a process whereby I could

ask questions about these incidents or episodes of care and learn more about how consumers experienced and made sense of them.

3.8. Analysis

Transcriptions of interviews and field notes from observations and informal interviews were analyzed through constant comparative analysis technique as they were collected. NVivo 12 qualitative software was utilized to organize these data and to facilitate the process of thematic coding. Consistent with grounded theory ethnography methods, I used memos throughout the analysis process to track decision making and allow potential backtracking and re-analysis as necessary (Babchuk & Hitchcock, 2013; Bamkin, 2016; Charmaz, 2006; Charmaz & Mitchell, 2001). Although there is a memo function in NVivo 12, I found tracking through a journal to be more helpful and relied on this method.

A process of open coding was used to generate preliminary codes for the raw text data and to facilitate analytic direction (Charmaz, 2006; Creswell, 2018; Maxwell, 2012). Charmaz (2006) suggests that open coding can be conducted through a variety of methods, including line-by-line and incident-to-incident coding. I utilized an incident-to-incident version of open coding in part because I had been taught this technique during my Master of Social Work research. I also avoid the line-by-line coding method because I have found it to be disjointed, fracturing the experiences related to a given phenomenon rather than facilitating a holistic understanding of an event. Once my open coding framework was developed, I met with two members of my supervisory committee (Dr. Small and Dr. Jenkins) to discuss the framework. These committee members were provided with copies of cleaned transcripts and asked to independently code them. The three of us then met to discuss the independently derived codes that each had developed, and through discussion, a shared coding framework was co-constructed. Analyzing this process through a social constructivist lens, this intertwined two other people in the meaning-making process of my research. After meeting with Dr. Small and Dr. Jenkins, I returned to my coding and made adjustments based on our discussions and my interpretations.

During the course of conducting interviews with consumers, one participant suggested a “member checking” process and volunteered to assist with this. I discussed

this request with my senior supervisors, and it was agreed to attempt this form of member checking to support the accuracy and internal validity of findings. I collected blocks of text from a variety of interviews that had been coded and placed them into a Word document. These blocks were large enough to provide context and had already been cleaned of any personally identifying information. This text document was then brought to a pre-arranged meeting with that consumer participant. The participant reviewed the blocks of text and then was asked to reflect on what meanings they found. This process was recorded in field notes, and the participant was provided with an honorarium (CAD 30) for their time. During the course of conducting further interviews, another participant asked to participate in a similar manner, and the process was repeated. This process was informative and led me to reconsider some of my earlier coding and interpretations.

These preliminary codes were then used to construct an initial coding framework of themes and concepts within which small blocks of text were sorted and categorized in NVivo 12 software. The next step in the analysis of these data utilized focused coding, whereby larger blocks of text and concepts were sorted within themes, and initial codes were tested for analytic strength (Charmaz, 2006; Creswell, 2018). Axial coding was then undertaken, whereby themes and sub-themes were linked and contextual depth was added to the analysis. Finally, a process of theoretical coding (Charmaz, 2006; Denzin & Lincoln, 2011) linked focused codes toward an overarching theme or hypothesis on the phenomenon of embedded police officers in mental health treatment teams. I found that the organizational structure of NVivo 12 software was not as helpful as I had hoped and therefore turned to a more manual “cut-and-pile” method that I had learned through mentorship from an experienced qualitative researcher. I manually printed my coding framework from NVivo and then physically cut blocks of text corresponding with coded events, colour coded these, and arranged them with tape on the walls of my office. This allowed me to spatially arrange themes and their connections as well as to make changes fluidly as I reconsidered and tested my emerging understandings of the studied phenomenon. I then used string to facilitate additional linkages between groupings of codes by connecting different themes and adding a third dimension to my analysis.

Consistent with the grounded theory ethnography methods that inform my research, I then undertook a draft-writing process as part of my analysis (Charmaz,

2006). This draft writing helped to synthesize ideas as well as test how these could be conveyed in combination with coded quotes from participants. This draft-writing process involved multiple rounds of feedback from committee members, starting with individual chapters and culminating with the entire dissertation document. My ideas were thereby refined and the readability of my drafts improved. Through this process I also sought to identify, describe, and construct theory from my findings. Grounded theory ethnography methods call for theory generation that is descriptive rather than explanative, but theory generation remains a primary goal (Charmaz, 2006). While my analysis was able to produce descriptive themes, it fell short of identifying an overarching theory related to the embedding of police officers in the ACT model. Because of this shortcoming, I have identified my research as being informed by grounded theory ethnography rather than claiming absolute adherence to these methods.

3.9. Presentation of Findings

The three manuscript chapters that follow present major themes that emerged from my data, under three headings: agent of change versus agent of social control; housing and homelessness; and flow and discharge from ACT. The order of their presentation was finalized during the draft-writing process in collaboration with my committee members and is intended to enhance the readability of results. These themes were not what I expected when conceiving of this research project, and they do not directly address my overarching research question. Although some might identify this as a weakness of my research, I view it as a strength and a sign that I adhered to my inductive methods and their social constructivist underpinnings.

Although I used interview guides with questions that were designed to elicit responses to my overarching research question, my participants guided me in different directions. All participants knew that I was interested in studying the impacts of embedding police officers in the ACT model, but it was evident from the first interview that this was a sensitive and nuanced topic for most of them. Questions that directly probed potential impacts of the embedded ACT officers often produced short responses or even silence. Instead of forcing participants to answer questions that were important to me, I chose an approach that allowed participants to unpack topics and themes that were central to them in this police-embedded ACT model. This made interviews more casual and facilitated rapport building. I believe that these methods also reduced the

potential power imbalance between me as a researcher and my participants. Allowing participants to share stories that were important to them produced rich descriptive detail. In some cases, this included direct or indirect reference to how the embedded police officers shaped these experiences. As interviews and ongoing analysis progressed, I began tailoring the interview guides to fill in gaps and test dominant themes. This allowed me to saturate and refine these themes, but it also took me farther from my original research question and objectives. Although my findings appear distal to my overarching research question, I believe that they are important and that they provide a glimpse into the workings of these police-embedded ACT teams. I also believe my findings provide a foundation for future research that can continue to explore this unique treatment model.

Chapter 4. Agent of Change versus Agent of Social Control

Abstract

Background: Assertive Community Treatment (ACT) is an evidence-based psychiatric intervention for consumers with severe mental illness and has been recognized for its ability to reduce hospital utilization rates and increase treatment retention for a complex cohort of consumers with high service needs. However, the intensity and potentially intrusive nature of ACT service delivery has led to critiques that the model is prone to promoting paternalistic and coercive treatment practices. In several municipalities in the Canadian province of British Columbia (BC), ACT has been uniquely modified through the addition of police officers to treat the most complex mental health consumers. However, the addition of police officers presents a variant that has yet to be rigorously described or evaluated through peer-reviewed research. My research begins to address this void through a qualitative exploration of how the embedding of police officers within the ACT model shapes perceptions of coercion for consumers and service providers.

Methods: Grounded theory ethnographic methods informed my data collection and analysis. I collected data from 47 in-depth qualitative interviews with ACT service providers (N = 23) and ACT consumers (N = 24), as well as conducting targeted ethnographic fieldwork consisting of informal interviews and observational fieldwork.

Findings: My recruitment methods facilitated the enrollment of consumers whose voice has been largely absent from previous qualitative research, and my findings revealed stronger themes of coercion than previously reported. My results show that variations in consumer autonomy, agency, and input into treatment decisions could either mitigate or aggravate how treatment interventions were perceived on a continuum of coerciveness. My findings raise concerns about enhanced perceptions of coerciveness and social control associated with the extensive use of community treatment orders and the addition of embedded police officers in the ACT model. **Conclusions:** The addition of embedded police officers within ACT, coupled with the extensive use of community treatment orders, combine to enhance experiences of coercion for both service providers and consumers. I identify specific interventions that service providers can employ to decrease perceptions of coercion and increase overall satisfaction with ACT.

4.1. Introduction

The overarching intent of this research was to explore how the phenomenon of embedding police officers in the Assertive Community Treatment (ACT) model shaped treatment experiences and health outcomes. During the early stages of data collection, a dominant theme related to coercion in ACT treatment emerged as central to participants, but was not always clearly connected to the unique police embeddedness phenomenon. Consistent with my inductive research methods, I pursued this dominant theme despite the lack of explicit connection with the overarching objectives of this research, because of its importance to participants.

ACT is arguably the most intense form of outpatient psychiatric treatment for “severe” mental illness, a condition marked by functional disability and high social needs in addition to a serious and persistent mental illness (Lerbaek et al., 2015). Due to the intensity of ACT service, and the model’s substantial economic footprint (Chandler & Spicer, 2002; Clark, 1997; Latimer, 1999, 2005), ACT is usually reserved for individuals with the highest use of expensive emergency and inpatient psychiatric hospital services (McGrew & Bond, 1995; McHugo et al., 2007; Randall et al., 2012; Teague et al., 1998). The ACT model was specifically designed to reduce hospital use for this population and has been championed as a gold-standard treatment approach because of its demonstrated efficacy in this treatment domain (Bond & Drake, 2015; Coldwell & Bender, 2007; McHugo et al., 2007; Monroe-DeVita et al., 2011).

The ACT model has been standardized through fidelity measurement tools, and higher fidelity is usually associated with more positive outcomes for healthcare systems (Bond & Drake, 2015; Bond et al., 2001; Cuddeback & Morrissey, 2011; Morrissey et al., 2007). High-fidelity ACT service delivery is characterized by several features, including: multidisciplinary staffing; shared caseload (with a clinician-to-consumer ratio of 1:10 or lower); frequent contact with consumers, primarily through outreach; around-the-clock service delivery; and internal capacity to provide wraparound treatment rather than brokering to other services (Bond & Drake, 2015; Bond et al., 2001; Dixon et al., 1997; Morrissey et al., 2007; Salyers et al., 2013; Stein & Test, 1980).

4.1.1. The British Columbia (BC) Context

The emergence of police-embedded ACT in BC finds its genesis in advocacy from municipal police departments. Beginning over a decade ago, BC police began emphasizing that a “mental health crisis” caused by treatment gaps was taxing their resources beyond capacity and contributing to unnecessary police involvement for individuals with mental illness (Szkopek-Szkopowski, 2013; Thompson, 2010; Wilson-Bates, 2008). This advocacy contributed to the creation of a police-embedded ACT model in several BC municipalities (Costigan & Woodin, 2018; Victoria Police Department, 2017; Saltman, 2019; Szkopek-Szkopowski, 2013; Wilson-Bates, 2008). As these newly formed police-embedded ACT teams reached capacity, further police activism precipitated the creation of several short-term treatment teams with embedded police officers, designed to bridge and funnel consumers towards ACT enrollment. I have used the pseudonym Assertive Short-term Program (ASP) to identify these teams in order to conceal the specific location of data collection and increase confidentiality for participants.

The decision of these municipal police forces to use ACT as one of the models in their collaboration with mental health treatment is important because the ACT model is well defined through fidelity measurement tools and extensive research. The ACT model can therefore serve as an anchor for analyzing and making meaning of collaboration between mental health treatment and policing and how this modification of police embeddedness shapes experiences and outcomes. Although there has been considerable appetite in BC to create and expand police collaborations with mental health treatment, it is important to underscore that the embedding of police officers in an ACT model is virtually undocumented in peer-reviewed literature, meaning that its short- and long-term implications are largely speculative.

4.1.2. Coercion and ACT

Concerns about potential coercion and lack of consumer autonomy are longstanding critiques of psychiatric treatment in general (Campbell & Davidson, 2009; Carroll, 1991; Crilly, 2008; Davidson & Campbell, 2007; Gomory, 1998; Kisely et al., 2017; Roskes, 2009; Stuen et al., 2015; Thøgersen et al., 2010). This is especially the case in jurisdictions that have legislative mechanisms to compel involuntary detention in

hospitals (and sometimes involuntary treatment) (Aagaard et al., 2016; Cuddeback et al., 2011; Lamberti et al., 2014; Lofthus et al., 2018; Monahan et al., 2005; Moser, 2007; Thøgersen et al., 2010). Qualitative research suggests that for individuals with severe mental illness, involuntary treatment in hospital settings can be particularly coercive and even dehumanizing (Campbell & Davidson, 2009; Krupa et al., 2005; Redko et al., 2004; Thøgersen et al., 2010).

The intensity of ACT service delivery has led some researchers to refer to it as a “hospital without walls” (Morrissey et al., 2007; Santos et al., 1995), and it has been critiqued for its potential to contribute to paternalistic and coercive treatment practices (Appelbaum & LeMelle, 2007, 2008; Davis, 2002; Watts & Priebe, 2002). The paradox of ACT is that even if service providers seek to deliver treatment in a manner maximizing consumer autonomy, at its core, ACT teams engage with a population preferring to disengage from psychiatric treatment (Jochems et al., 2012; Lerbaek et al., 2015; Monahan et al., 2005; Watts & Priebe, 2002). Some research has shown that ACT consumers are also particularly attuned to potentially coercive methods, as many have previously experienced overtly coercive treatment, especially during periods of forced psychiatric hospitalization (Watts & Priebe, 2002). Noting this target population, some researchers have stated that coercion may be inevitable in this model, as ACT service providers seek to assertively re-engage these consumers in treatment (Thøgersen et al., 2010). Some have argued that the intensive and sometimes intrusive nature of ACT interventions into multiple domains of consumers’ lives (medical, social, housing, financial, and psychiatric) can also create challenges related to privacy and confidentiality, as well as ethical dilemmas in choosing between the needs and wishes of consumers versus those of providers and the larger treatment system that service providers work within (Crilly, 2008; Garside & Maher, 2006; Lerbaek et al., 2015, 2016; Szmukler, 1999; Thøgersen et al., 2010; Williamson, 2002). However, there are also contrasting research findings showing that the ACT model can create opportunities for service providers to use subtle forms of persuasion in a community context, reducing the use of more overtly coercive methods, such forced hospital admission, where physical and pharmacological restraints are utilized (Aagaard et al., 2016; Angell et al., 2006; Mfoafo-M’Carthy & Shera, 2012).

Despite concerns about paternalism and coercion, ACT service providers can describe their treatment interventions in friendlier terms, such as “persuading” or

“externally motivating” consumers to engage in behavioural changes, rather than acknowledging that they use overtly coercive methods (Neale & Rosencheck, 2000). It has been noted that “social desirability” (Salyers et al., 2013) may be one reason why service providers deny using coercive methods, even if they actually believe that they do. Most qualitative research examining the experiences of ACT consumers has pointed to low levels of perceived coercion in ACT treatment (Aagaard et al., 2016; George et al., 2016; Krupa et al., 2005; Lofthus et al., 2018; Thøgersen et al., 2010; Tschopp et al., 2011). However, research methods allowing ACT service providers to regulate the recruitment of consumers for these studies may be biasing results towards more positive outcomes.

Although often blurred, distinctions have been made between informal and formal coercion. Informal methods of coercion frequently refer to perceptions resulting from “leverage” (e.g., withholding services or offering incentives), as well as direct demands or threats (Campbell & Davidson, 2009). Formal means of coercion often refer to legislated mechanisms that formally mandate treatment, such as specific mental health legislation or criminal court-imposed conditions of community release (Campbell & Davidson, 2009; Lamberti et al., 2014; Monahan et al., 2005; Moser, 2007). Investigations into experiences of coercion have revealed that the topic is highly complex. For example, research has shown that legal mechanisms that compel treatment are not always experienced as coercive (Lamberti et al., 2014), and that more subtle or “hidden” forms of persuasion can be experienced as extremely coercive (Campbell & Davidson, 2009). Results such as these emphasize the nuanced positions that exist in perceptions of coercion and underscore the strength of qualitative methods in this area because of the descriptive details they can facilitate.

In some jurisdictions, ACT teams use legislative mechanisms (formal coercion) such as Community Treatment Orders (CTOs) that mandate consumers’ compliance with community treatment. The use of CTOs in ACT has been the subject of critique including concerns that CTOs remove consumer agency in treatment decisions, thereby contributing to coercive and paternalistic treatment practices by service providers (Lofthus et al., 2016; Mfoafo-M’Carthy & Shera, 2012; O’Reilly et al., 2016). Another critique is that although CTOs are used abundantly in many jurisdictions (Rugkåsa, 2016), there is a lack of scientific evidence that their use improves treatment outcomes (Heun et al., 2016).

The power of CTOs in BC comes through provincial legislation known as the BC Mental Health Act. The Mental Health Act allows for the involuntary detention and treatment of individuals with mental illness if certain criteria are met (British Columbia Ministry of Health, 2005). It has been argued that when compared to legislation in other Canadian jurisdictions, BC's Mental Health Act is particularly broad in its criteria for involuntary committal, as well as in its provisions for involuntary treatment (Browne, 2010; Johnston, 2017; Verdun-Jones & Lawrence, 2013; Woo & Dhillon, 2017). The Mental Health Act also uses paternalistic language such as "care," "control," and "supervision" in reference to the use of mandated treatment (Johnston, 2017). These terms, and their lack of clarification within this legislation, could be critiqued as extending the Act's powers beyond the requirements of "treatment" and into the realm of social control.

Although some have argued that the BC Mental Health Act violates Section 7 of the Canadian Charter of Rights and Freedoms, it has yet to be challenged on such grounds at the level of the Supreme Court of Canada (Verdun-Jones & Lawrence, 2013; Woo & Dhillon, 2017). It has also been argued that the BC Mental Health Act and similar mental health legislation in other jurisdictions may violate the United Nations Convention on the Rights of Persons with Disabilities (Szmukler et al., 2014). A recent report investigating involuntary hospital treatment in BC found serious flaws in the current system of involuntary hospital-based treatment, citing poor levels of compliance with procedural requirements such as documentation, lack of independent oversight, and failures in ensuring that consumers are aware of their rights and the mechanisms they can use to challenge involuntarily detention and treatment (Office of the Ombudsperson, 2019). This report conspicuously omitted investigation of involuntary community treatment mandated through the Extended Leave provisions of the BC Mental Health Act.

While the topics of coercion and paternalism are prolific in ACT literature, the emergence of ACT with embedded police officers is a unique variation that appears to be largely undocumented and unevaluated. Thus, my study addresses a notable gap by exploring how the embedding of police officers in ACT may shape service delivery experiences and health-related outcomes related to coercion from the perspectives of consumers and service providers. My findings should be considered within the context of

the formal legislation governing involuntary treatment in BC, given its specific features and extensive powers.

4.2. Methods

Grounded theory ethnographic methodology, informed by a social constructivist paradigm, guided the conduct of this research. Grounded theory ethnography is a qualitative research method combining some features of conventional grounded theory with focused ethnographic fieldwork that concentrates on *phenomena* over *setting* (Babchuk & Hitchcock, 2013). Grounded theory ethnography allows more flexibility than traditional grounded theory but retains key features such as in-depth interviews, constant comparative methods, theoretical sampling, data collection towards attaining coding saturation, and an objective of generating descriptive theory about a given phenomenon (Charmaz, 2006, 2009). The flexibility found in grounded theory ethnography that distinguishes it from conventional grounded theory can be attributed to its social constructivist foundation. Social constructivism calls for research creativity and acknowledges that multiple discourses exist about any given phenomenon, and that these are necessarily shaped by the world views of participants (Charmaz, 2006; Creswell, 2018). Social constructivism also assumes that the research process will draw researchers into the meaning-making process with their participants (Charmaz, 2006; Taylor, 2018).

Consistent with the grounded theory ethnographic methods that inform my research, I used both interviews and focused ethnographic fieldwork to gather data. I conducted 47 in-depth qualitative interviews with ACT service providers (N = 23) and consumers (N = 24). Recruitment of ACT service providers was undertaken primarily through email invitations forwarded to potential participants through their employer. I also utilized snowball sampling and peer-driven methods to bolster recruitment and build a purposeful sample. Service provider interviews lasted 40–90 minutes and were conducted at a variety of locations, including Simon Fraser University, coffee shops, offices, and community centres. In keeping with conventions for this type of research, I did not provide honoraria to service providers to compensate them for participating, as their involvement was viewed as being within the scope of their professional roles.

I utilized several approaches to recruit ACT consumers and to avoid limitations noted by previous researchers. A survey of ACT qualitative research showed that consumers have been primarily recruited through their treating ACT teams, and that the resulting research samples likely focused on consumers whom ACT service providers considered to be “engaged” in service delivery and psychiatrically “stable” (for examples, see: Cuddeback et al., 2011; Krupa et al., 2005; Milbourn et al., 2014; Thøgersen et al., 2010; Watts & Priebe, 2002). My recruitment of consumers was entirely independent of treatment providers, and my inclusion criteria did not exclude consumers on the basis of psychiatric symptoms except in three cases where psychosis created barriers to completing the informed consent process. I assert that my recruitment methods and inclusion criteria have likely brought forward a perspective that has been absent from previous qualitative inquiry into ACT.

I undertook the recruitment of ACT consumers primarily through three ongoing prospective cohort studies of the British Columbia Centre on Substance Use (BCCSU): the Vancouver Injection Drug Users Study (VIDUS), the At-Risk Youth Study (ARYS), and the AIDS Care Cohort to Evaluate Exposure to Survival Services (ACCESS). Details of the methodology used in these studies have been described by other researchers in great depth (see Strathdee et al., 1997; Wood et al., 2001). In brief, prospective cohort participants have been recruited through snowball sampling, outreach, and self-referral. VIDUS is composed of HIV-negative adults who use drugs. ACCESS is composed of HIV-positive adults who use drugs (including VIDUS members who subsequently test positive for HIV after enrollment in VIDUS). ARYS is composed of street-involved youths and was created to research a variety of factors influencing the health of this population. For data collection, all of these prospective cohort studies utilize interviewer-administered questionnaires, clinic visits and blood collection, and qualitative interviews.

To facilitate the recruitment of ACT consumers through the BCCSU research mechanisms, I added items to questionnaires administered to participants in these three cohorts. Potential participants flagged through these questionnaires were then screened by research staff at two storefront BCCSU offices. Potential participants meeting eligibility requirements were provided with a brief synopsis of the study, and interviews were scheduled for interested participants. My initial plan was to interview consumers primarily at the storefront offices of the BCCSU, but I encountered barriers that called for more flexibility in meeting consumers “where they were at.” Therefore, I also conducted

in-depth interviews at other locations, including Simon Fraser University, consumers' residences, coffee shops, community centres, and emergency shelters. Interviews with consumers lasted between 20 and 80 minutes, and honoraria of CAD 30 were offered to compensate them for their time.

4.2.1. Description of Participants

Although presenting characteristics of individual participants (e.g. gender, profession, experience, diagnosis) with excerpts from their interviews could enhance contextual detail for readers, I chose an alternative approach to maximize confidentiality. I assigned a numerical code to each participant and reported potentially identifying details of my participants in aggregate form only. Quotes identified participants through a numerical code followed by the letters "C" for consumer participants and "SP" for service providers. Consistent with the social constructivist foundations of grounded theory ethnography, I also presented my findings using terms such as "many," "most," "some," and "few," rather than numerical values. My intention is to provide readers with the relative strength of a given theme while avoiding positivist assumptions related to the certainty of findings based on numbers alone.

Service Providers

The age of service provider participants ranged from 31 to 63 (mean = 43 years). Nine of my service provider participants were female, and 14 were male. Participants had between one and seven years (mean = 3 years) of experience working on an ACT team (inclusive of any jurisdiction) and between two and 35 years (mean = 11 years) of total work experience in their given profession or occupation. My service provider participants included representatives from several professions: physicians, nurses, social workers, police officers, occupational therapists, concurrent disorders counsellors, and peer support specialists. With regards to education credentials, 14 participants had completed graduate degrees (inclusive of physicians), seven held bachelor degrees, and two had obtained diplomas.

Consumers

Seventeen consumers identified as male and seven as female. Their ages ranged from 25 to 62 (mean = 43 years). Thirteen participants self-identified as

Caucasian, nine as Indigenous (respectfully inclusive of First Nations, Métis, and Inuit), and two as black. Nine participants were recruited from VIDUS, two from ACCESS, and five from ARYS. Eight individuals were recruited from outside of the cohort research, primarily through observational fieldwork and snowball sampling. Sixteen consumers self-reported their primary diagnosis to be schizophrenia, four reported schizoaffective disorder, one reported “psychosis,” two reported bipolar disorder, and one reported “depression and anxiety.” Participants did not necessarily agree with their psychiatric diagnosis. Fifteen participants reported at least one hospitalization in the previous year (two participants reported that their hospitalizations were for primary care medical issues rather than being mental health related), and the length of hospital admission ranged from one to 90 days. Most of the ACT consumers in my sample reported that they were currently mandated to receive treatment, under the Mental Health Act, with 19 reporting that they were on Extended Leave (community treatment orders) at the time of their interview. An additional three participants reported that in the previous two years, they had been successful in Review Panel hearings to remove themselves from Extended Leave. All consumer participants had previous experience with involuntary detention and treatment under the Mental Health Act.

I also conducted over 90 hours of focused observational fieldwork and informal interviews in public spaces of The Block, including areas such as streets, alleyways, parks, and community centres, as well as more private spaces (e.g., a participant’s suite), if invited. Consistent with grounded theory ethnography methods, my observational fieldwork was focused geographically and temporally to maximize potential opportunities to experience episodes of ACT service delivery (Charmaz, 2006). I used a verbal script to identify myself and my purpose during this fieldwork. Field notes and voice memos were used to record fieldwork, and this information was used to inform analytical direction, as a source of primary data, and to triangulate results. I also used my observational fieldwork as a mechanism to recruit for in-depth interviews of consumers who were not in the BCCSU cohorts. Doing so allowed me to pursue themes that emerged during observational fieldwork through in-depth interviews with the people directly experiencing an observed phenomenon (such as a specific episode of service delivery where a service provider administered medication to a consumer in the company of a police officer).

4.2.2. Analysis

In-depth interviews were audio recorded, transcribed, and uploaded along with field note data to NVivo12 qualitative software to facilitate analysis. Analysis was an ongoing process during data collection, and I pursued emergent themes during the recruitment, interview, and fieldwork processes in a manner consistent with the constant comparative analysis technique (LaRossa, 2005). After interviews were completed and transcribed, I met with two members of my PhD committee (Dr. Small and Dr. Jenkins) to collaboratively develop a coding framework. I also compiled blocks of deidentified text from transcripts to review with two volunteer ACT consumers as a means of member checking, to inform analytic direction, and to verify the developing codebook. These volunteer consumers were offered an honorarium (CAD 30) for their time. The coding framework was then applied to all transcripts, and larger themes prominent for both service providers and consumers were analyzed in further detail. A social constructivist lens was used to better understand congruencies and incongruences in the experiences (multiple discourses) of different individuals related to similar phenomena (Charmaz, 2006; Creswell, 2018). Axial coding was then employed to analyze relationships between codes, and themes were tested for analytic strength and potential subjugated storylines (discourses) (Babchuk & Hitchcock, 2013; Charmaz, 2006; Denzin & Lincoln, 2011). Once dominant themes were identified and tested for analytic strength, a process of selective coding was used to link themes together and to create a cohesive storyline (Charmaz, 2006; Denzin & Lincoln, 2011). A process of draft writing was then used toward producing a descriptive understanding (theory) of each phenomenon (Charmaz, 2006).

4.3. Results

I present my findings through two broad overarching themes: (1) experiences emphasizing perceptions of coercion and (2) experiences mitigating perceptions of coercion. My findings showed that coercion was often experienced on a continuum rather than in absolute or definitive terms. My findings also suggested that individuals perceived coercion differently, even when experiencing the same phenomenon or intervention, and that even the same individual could experience an intervention as coercive in one context but not in another. Although seemingly contradictory, these

findings can be understood through a social constructivist lens. This theoretical lens accepts that meaning making is co-constructed by researcher and participant and that multiple discourses can exist about a single phenomenon, even for the same person (Charmaz, 2006).

4.3.1. Experiences of Coercion

Service providers and consumers in this study shared strong perceptions of coercion in relation to the police-embedded ACT model, and both the officers themselves and the powers of the Mental Health Act were often central to these concerns. My data analysis elicited several subthemes through which I present findings associated with enhanced concerns of coercion. These subthemes are: agent of change or agent of social control; lack of autonomy and not feeling heard; treatment as trauma; surveillance and privacy issues; and legislation and formal mechanisms of control.

4.3.2. Agent of Change or Agent of Social Control: “We became part of the policing system”

This theme primarily focused on experiences of service providers and their struggles with perceived polar identities of being agents of change versus agents of social control. I noted that the police officer participants in this study did not share concerns about this dialectic to the same degree as healthcare service providers. For participants who did express these identity concerns, being an agent of change often personified their “ideal” view of themselves in their respective healthcare disciplines, whereby their clinical interventions were based on the needs of consumers with the intention of affecting positive and lasting change in those consumers’ lives. Conversely, being an agent of social control was usually perceived negatively by service providers, as it had connotations beyond the treatment relationship, towards “controlling” and “policing” the behaviours and lives of consumers.

The following service provider succinctly stated their displeasure about, yet tacit acceptance of, their perceived role as an agent of social control:

Yeah. *I’m* an agent of social control. I mean, I actually think that. And that’s not why I went into nursing. . . . Yeah, it’s awful. [Laughs nervously] . . . There’s moments that I think, “You know what? I’m just not going to think about this too

much.” Otherwise I couldn’t do my job. Like, if you think about this too deeply . . . Yeah, I’m an agent of social control, for sure. “Take your medication. You need to have this injection. I know you don’t believe that you do, but you’re under Extended Leave. I’m obliged to do this with you. I’m sorry that you’re really mad. You can tell me to ‘fuck off.’ That’s okay. But I’m going to come back tomorrow.” (ACT 2SP)

This participant went on to state that returning would likely include bringing a police officer to the next encounter to “send a message” to the consumer. Interestingly, it was not necessarily the action that a participant undertook that led to perceptions of coerciveness, but rather the identity that the service provider felt when undertaking that action. In other words, giving an injection to a consumer could be experienced as coercive in one context but not in another and was mediated by the perceived identity under which it was delivered. Interventions that participants identified as being consistent with the role of agent of change were usually not experienced as coercive, but that same action could be experienced as coercive when undertaken under the identity of agent of social control.

The service provider who provided the previous quote later spoke about examples where these identities blurred, making it difficult to differentiate whether their interventions were towards change or control. Importantly, some service providers believed that the intention or motivation behind an intervention also mediated which identity category it would fall within and the degree to which it was perceived as coercive. For example, one participant described how providing incentives to a consumer to clean their room was part of being an agent of change; however, using the same incentives when administering an injectable medication was experienced as coercive and associated with being an agent of social control. The key point of difference was that the incentive was used to motivate a consumer to do something in one situation, but in the other it was used to allow the service provider to do something to the consumer.

Related to this, the majority of service provider participants openly wrestled with competing pressures and priorities when the needs of consumers appeared to clash with the needs of the healthcare system, the police, or society at large. Some service providers spoke directly of perceived pressure to address “delinquent” or “nuisance”

behaviours of consumers as part of their treatment interventions, due to the police partnership in this ACT model. The following data excerpt illustrates tension arising from the perceived need to manage emergent situations that would conventionally have been handled with police intervention but were now being diverted to ACT healthcare service providers:

We get calls that are supposed to be handled by police but police are no longer handling it. They [the police] are sending [them] to us. I think it just shows how there is a shift from what an ACT team or a mental health service is supposed to be and becoming a diversion [function] in terms of some of the workload that police are dealing with. Understandably they're [the police] dealing with a lot of mental health issues on the streets, but when we become an extension of the police work, I think it becomes problematic. It changes our relationship with our clients, that now we became part of the policing system . . . this just takes us very far [away from] what an ACT team is supposed to do. An ACT team is for clients who have failed to benefit from existing mental health services. . . . It's a huge investment. It takes years to build and years to establish and years to stabilize clients, but when it becomes a Band-Aid and a 911 call, it's not an ACT team. (ACT 19SP)

Concerns that the stakeholder relationship between police and mental health treatment had resulted in a blurring of lines between what was considered a “police call” and what should be addressed by ACT service providers were common among participants. For some, this blurring was central to concerns about coercion because the stimulus or motivation for these interventions was driven by police stakeholder needs rather than clinical healthcare decision making.

Almost all of my service provider participants shared that they felt more positive about themselves as healthcare clinicians (agents of change) when consumers were in agreement about and receptive to their treatment interventions. Conversely, many saw interventions, and themselves, more negatively (as agents of social control) when their interventions resulted in consumer resistance or avoidance. Most service providers preferred to have amicable treatment interactions with consumers and felt discomfort with resistance that they associated with consumer perceptions of pressure and coercion.

To summarize, I found that service providers wrestled with competing identities as agents of change versus as agents of social control, with the latter being associated with enhanced concerns about coercive practices. I also found that there was some blurring between these identifies, and that the motivations behind an intervention often influenced where it would fall on a continuum of coerciveness. In addition, my findings underscored concerns that the embedding of police officers in ACT created a blurring of roles, resulting in service providers feeling compelled to respond to situations that they believed should be under the purview and responsibility of police. My findings also showed that service providers preferred having consumers perceive their interventions positively, and that this fostered identification as an agent of change.

4.3.3. Lack of Autonomy and Not Being Heard: “I feel unheard, I feel not listened to...I feel belittled”

Within my data, only one consumer² experienced a complete absence of coercive practices related to their current ACT treatment. All other consumer participants shared prominent perceptions of paternalism, unwanted pressure or persuasion, and overt coercive practices in relation to ACT treatment interventions. These narratives were often associated with lack of autonomy or personal agency, as well as with not being listened to or heard by service providers.

My analysis indicated that interventions limiting personal autonomy were almost universally experienced as either coercive or paternalistic by consumer participants. Almost all consumers provided examples ranging from their initial enrollment in ACT services to decisions about medications (types, frequency, mode of administration), as well as frequency and location of interactions with service providers, citing these as interventions that felt coercive in that the consumer lacked choice or input. The following data excerpt illustrates these dynamics via a consumer’s frustration with their visit schedule:

They should ask people if they mind. You know, I don’t really like being checked into every day. I don’t really like that. I don’t know. They should ask me if I mind. I

² This participant also reported that they were not on Extended Leave and not currently prescribed any psychotropic medications. Findings to follow will show that these factors probably reduced the likelihood that service provider interventions would be considered coercive.

told them that before, but they just kept doing it. I told them, you know, “What’s this checking in for?” And I told them when I first started seeing them, I wanna see them once a month, for the injection, and that’s it. But they come and knock on the door anyways, so they don’t listen. (ACT 31C)

This example is important, not only because of its focus on lack of autonomy and the perception of not being listened to, but also because it speaks to the participant feeling that they were being monitored through treatment contacts. Perceived monitoring is an issue that came up repeatedly in my data and is described more fully under the related theme of surveillance and privacy issues.

My analysis demonstrated that the process of enrollment in ACT could be a difficult transitional period for both consumers and service providers and that systemic pressure (e.g., frequency of intakes or short transition periods and lack of bridging by referring treatment providers) contributed to decreased consumer autonomy. Most participants described a lack of agency for consumers in the decision to be referred to ACT. The absence of any therapeutic relationship between service providers and consumers at the initiation of ACT service delivery, coupled with the increased assertiveness and intensity of ACT compared with previous treatment interventions, often heightened consumers’ perceptions that they lacked autonomy in ACT treatment decision making.

Almost all consumers recalled a day when ACT service providers simply showed up in their lives by knocking on their door or locating them out in their daily activities, indicating a lack of forewarning that they had been enrolled in ACT. Most consumers were perplexed as to why they had been chosen for ACT service delivery, and were unaware of who had referred them for this intensive service. None of my consumer participants recalled initially wanting ACT enrollment or having been involved in a collaborative decision-making process prior to enrollment. Most reported that they’d had no prior knowledge of ACT or idea of what ACT treatment would look like until they started receiving services. The intensity of ACT services was experienced by consumers as a drastic change from previous service delivery and treatment experiences. One consumer provided an illustrative account of an experience common among participants as ACT treatment was initiated:

This person walked up to me, and one of the workers . . . at the church [emergency shelter] came up to me and said the Mental Health Act team is gonna be coming to talk to you. And all of a sudden [redacted names of ACT service providers] was there. I mean, all three of them were there, and we're in a room. And they told me that I'm gonna start getting injections and that I had to take pills. (ACT 33C)

The previous data excerpt is interesting in part because the consumer used the phrase "Mental Health Act team" to describe their ACT team, thereby twinning the legislation of involuntary treatment with the ACT model. This account also underscores a common theme in the reports of both consumers and service providers: if the initial meeting between consumer and service providers revolved around the administration of medication, this impeded the formation of a therapeutic relationship.

Most service providers agreed that consumers lacked choice in the process of ACT enrollment and that this created initial barriers to care provision. Almost all service providers perceived that the enrollment of ACT consumers was primarily driven by the imperatives and priorities of the larger treatment system within which these teams operated. The following excerpt from a service provider illustrates how the specific features of a transfer of care from a community mental health team to ACT impaired the ability to subsequently form therapeutic bonds:

. . . the last team, there was really, in terms of the handover to that team, there was really no handover for him. He [consumer] wasn't really aware. It was . . . just so abrupt, and then, you know, people [ACT service providers] showing up at his door saying "your injection is due" but there wasn't a lot of engagement, a lot of relationship . . . and so it was a very negative experience for him . . . (ACT 11SP)

Participants noted that consumers were often on Extended Leave under the Mental Health Act when transferred to these police-embedded ACT teams and therefore were legislatively mandated to treatment. Both service providers and consumers shared examples of this mental health legislation creating immediate power imbalances in their treatment relationships, which legally permitted the imposition of limitations on consumer input about treatment decisions. The words of one service provider illustrate a perceived

twining of Extended Leave and coercion in the local setting: “They’re coerced to treatment. Ninety percent of our clients are under Extended Leave. They’re coerced to treatment” (ACT 2SP). Another service provider shared a similar narrative but provided further description of a perceived lack of consumer agency associated with Extended Leave, explaining, “You can hire us to an extent, but you can’t fire us, is the saying in the [ACT] office. There is minimal choice, especially when a person is on Extended Leave” (ACT 15SP). This service provider later clarified that they meant that the system could “hire” ACT for consumers, but that once assigned to ACT, consumers were unable to fire their ACT team or disengage from treatment.

All of my service provider participants shared that they perceived it to be common and expected for consumers to want to disengage from ACT services, because previous treatment refusal and disengagement was usually a prerequisite of enrollment. However, the majority of service providers perceived that the lack of agency for consumers associated with Extended Leave exacerbated resistance to treatment. Service providers therefore struggled with beliefs that ACT consumers would fail or disengage from treatment if they were not on Extended Leave, but the service providers also experienced the power imbalance and coerciveness of Extended Leave as challenging. Although my findings call attention to the assumption of service providers—and the system they work within—that mandated (involuntary) treatment was necessary for some ACT consumers, my analysis did not provide clear justifications for this position. On the contrary, most service providers shared negative experiences related to involuntary treatment, such as resistance from consumers and barriers to forming treatment relationships.

My findings also cautioned that when treatment was deployed through police-embedded ACT, it necessarily came with an increased level of assertiveness and breadth that permeated multiple domains of a consumer's life, including finances, housing, medication, and social relationships. Further, my findings showed that consumers usually had not previously experienced psychiatric treatment interventions entering these domains of their lives, or if they had, certainly not to the extent experienced through ACT treatment. This point is important because while mandated treatment could be delivered through other models of care in this setting, the ACT model's ability to provide intensive wraparound services into psychosocial aspects of a consumer's life is far greater than in other treatment models. Therefore, while a mental

health team in this setting could use the same mental health legislation as ACT, the capacity to exercise this power would be mitigated by the lower intensity of a traditional case management model, wherein one service provider has responsibility for many consumers. My results therefore stressed that the structural aspects of service delivery that made police-embedded ACT unique also enhanced the level of monitoring and the enforcement potential of Extended Leave through the intensity of this model and its extensive reach into multiple domains of consumers' lives.

For consumers, lack of autonomy was almost always experienced as coercive and often resulted in some form of resistance. My analysis demonstrated that resistance existed on a continuum, from more passive responses (such as avoidance, apathy, and selective mutism) to aggression (verbal, directed at objects, and in rare cases physically assaultive). Interview data suggested that the most common response from consumers tended to be apathy and avoidance. The following report from a consumer participant emphasizes their perception of a dramatic power imbalance in the treatment relationship and how this necessitated compliance:

The shrink, she said, if you stay medicated for a year then we'll decertify you [change from involuntary to voluntary treatment]. And . . . I said okay, I'll play the game here, because I have no choice and with these guys. They got the power to ruin your life. I mean they can do whatever the hell they want and they don't answer to anybody, and we don't have any choice. . . . You know there's really no option. You're . . . totally under their control. There's nothing you can do, unless you know suck their cock and play along, I mean they can hurt you really bad . . . (ACT 45C)

Consumer perceptions of feeling powerless in their relationship with ACT service providers as described in the previous data excerpt were common. I also found that some consumers perceived a lack of accountability or oversight with respect to ACT service providers' use of Extended Leave provisions to compel them to comply with treatment. Several consumers also said they did not know whether they had any recourse or right to challenge their involuntary status, which in turn enhanced perceptions of coercion and feelings of hopelessness. During interviews, a common

prompt was to ask consumers about their experiences with Review Panels,³ but several consumers who were on Extended Leave indicated having no knowledge that this mechanism existed and denied that it had ever been explained to them by service providers. This is an important finding to note because the BC Mental Health Act specifically requires a process⁴ through which involuntary consumers are to be informed of their right to challenge that involuntary status and the mechanisms that are available to help them do so.

It was common for consumers to share a sense of hopelessness with regards to their involuntary treatment status, and perceptions that this eliminated their agency in treatment decisions. I found that for a small group of consumers, this led to extreme feelings of anger and resentment towards their ACT service providers. Related to this, I also found service providers experienced enhanced risk to their personal safety when consumers lacking autonomy in treatment decisions reached the point of expressing anger. Some service provider participants emphasized that these safety concerns necessitated the presence of embedded police officers in the ACT model. From this perspective, police presence was viewed as protection when carrying out interventions that consumers were likely to resist. This was seen as unique to police-embedded ACT because in other forms of community treatment without embedded police officers, service providers would not attempt such interventions. Rather, they would “recall”⁵ a consumer to hospital under the Mental Health Act (by means of the police), and the consumer would receive the same intervention (such as medication administration)⁶ in a hospital setting. In other words, the community service provider in those models of care would be insulated from the police process of detaining and transporting the consumer

³ A Review Panel is a formal mechanism through which an involuntary consumer can appeal their involuntary status.

⁴ The BC Mental Health Act uses a Form 13 to explain a consumer’s rights and the process to challenge involuntary status. This legislation requires that a Form 13 be reviewed with a consumer at the time of certification and every time certification is renewed.

⁵ Under the BC Mental Health Act, a Form 21 can be issued by community treatment providers if a consumer fails to comply with the conditions of their Extended Leave. The Form 21 is a warrant that commands any police officer to detain a given consumer and transport them to the nearest designated facility (hospital).

⁶ Under the theme “treatment as trauma” I will present findings showing the traumatic incidences experienced by many ACT consumers in hospital settings. Such trauma increased the power or negative consequences of being recalled to hospital and should be considered in relation to consumer perspectives.

to hospital, where the intervention would occur. An excerpt from a consumer provides a perspective on the “recall” process:

They [the ACT service providers] put out a Form 21 or Form 28 and then they [police] take you to the hospital. . . . Cops will come in and put you in cuffs and get you to the hospital and you’ll either get held in hospital for a number of days or you’ll just get your injection. . . . And it’s quite embarrassing, I don’t like that pretty much at all. (ACT 47C)

This example can be contrasted with an ACT service provider who would attempt this same intervention (i.e., administering an injection) in the community with the support of an embedded ACT officer rather than immediately recalling the consumer to hospital. It could be argued that administering this medication under the watch of a police officer prevents the potential trauma of the “recall process,” whereby the consumer would be detained and brought to hospital by police to receive that medication. However, some service providers noted that it also directly involved them in an imbalanced power relationship with that consumer due to the police officer’s presence, the power the officer held as an agent of state control, and the consumer’s knowledge that resistance would result in the same outcome (i.e., injection) after their forcible transportation to hospital. Related to this, my informal interview data also provided claims from some ACT consumers that they had been restrained by police officers in the community and injected with medications against their will by ACT service providers. These examples were rare, and my in-depth interviews and observational fieldwork did not provide data to triangulate these claims.

My findings revealed that most service providers found that the mere presence of embedded officers was usually enough to quell resistance or reduce the threat of escalating behaviour and hostility. This is exemplified in the following excerpt:

But clients would push back a lot and refuse to engage a lot more commonly on ACT when I am by myself. But when there’s an officer there, it changes things and they feel more obligated to interact because there’s police there. . . . Not that the police are doing all the talking, or really trying to be directive in any way. But just that presence does have an impact. (ACT 10SP)

Most of my service provider participants noticed that even in the absence of any action by the officer, that person's presence could shape treatment interactions. This may have been a by-product of consumers' experiences with police officers prior to their enrollment in ACT. The majority of my consumer participants shared stories of previous negative interactions with police officers, such as frequent street checks for identification, confiscation of belongings, and instances of perceived excessive force during arrests. I found that these previous experiences shaped how consumers experienced the embedded police officers within their treating ACT teams. Interestingly, some service providers saw the embedded officers in ACT as providing potentially "socially corrective" positive experiences for consumers who had previous negative experiences with police. These service providers shared their belief that because the officers were present for non-criminal justice reasons in the ACT model, interactions between the officers and consumers would be more positive, and that over time, this could "correct" consumers' negative feelings towards the police in general.

While some service providers appreciated the support of police in relation to treatment interventions and perceived it as necessary for their own protection, others saw the presence of officers as unavoidably interjecting enforcement and social control into their treatment relationships. The following excerpt succinctly explains: "The authority, it's the presence, it's the authority figure" (ACT 12SP). I found that the presence of an officer was usually associated with lower levels of overt resistance from consumers (e.g., posturing or verbal protests); however, it was often experienced as enhancing passive forms of resistance (avoidance or failure to engage) and as an impediment to the therapeutic relationship. This was not always the case, though, and I also found examples where the presence of a police officer could contribute to an escalation of resistance. Some service providers offered examples where the mere presence of an officer, and their perceived obligation to maintain order, led to an escalation in the use of force during an episode of treatment. The following excerpt provides an example of an interaction where police presence was perceived as contributing to escalation and the eventual use of force:

If you [consumer] yell . . . maybe they'll [police officer] raise their voice a bit, but generally not yelling back. But then it's like they [police officer] get more strict and then if . . . you're [consumer] gesticulating or they feel unsafe in any way, well

now we are talking handcuffs. And if we're talking handcuffs, then we're talking handcuff procedures . . . and then you're in the back of the car. (ACT 1SP)

The previous excerpt is also important because the service provider later went on to describe that they would have simply disengaged from the situation if the officer had not been there. In other words, the service provider believed that if the officer had not been present, this instance of use of force would have been avoided.

My analysis showed that consumer perceptions of coercion were not just associated with restrictions to personal autonomy, but also with perceptions of not having their input asked for, valued, or acknowledged by service providers. The following excerpt illustrated this perception: "I think it was ridiculous. I feel unheard, I feel not listened to, I feel unjust . . . I feel belittled" (ACT 33C).

It was also reported that some consumers experienced instances when their input and knowledge were devalued in comparison with the professional and "expert" knowledge of service providers. Treatment interventions undertaken in a context where consumer knowledge was routinely ignored were usually experienced in negative terms, and sometimes as coercive. One consumer discussed their experience of attempting to have their prescribed medication dosage increased due to breakthrough⁷ psychotic symptoms:

They . . . could've listened more better, and . . . just they could've listened more better than just following what they know because . . . they're the doctor or whatever. And then listened to the person who . . . was taking it. (ACT 41C)

This excerpt is also important because the consumer asked for an *increase* in their prescribed psychiatric medication. This stands out as a strong example of not being listened to because it contrasts with the predominant narrative of service providers, that consumers often wanted their psychiatric medications reduced. Many of my service provider participants expressed that they were unable to respond to these requests, or to listen to consumers' desires, because of perceived obligations to maintain a therapeutic

⁷ I use the term breakthrough to describe a brief, episodic increase in psychotic symptoms. This consumer shared that their psychotic symptoms (in this case, paranoid thoughts) were lessened due to their long-acting medications, but they still experienced episodes where these symptoms became pronounced and distressing.

medication dose. However, the previous data excerpt shows that the exclusion of consumer input appeared to be broader than just those resisting medications.

Some consumers also explained that the staff scheduling rotation in these ACT teams, coupled with team-based responsibility for consumer care, created barriers to even contacting a specific service provider, let alone reaching someone who would listen. One consumer noted:

They're all hard to get a hold of. . . . There's like a new worker almost every time, right. [participant looks frustrated] . . . They always send somebody different. . . . Yeah, it'd be nice to be able to get like one worker or two workers instead of like every . . . different person every week, right. (ACT 29C)

Barriers for consumers wishing to contact a trusted staff member were also acknowledged by some service providers: "Maybe we're a bit hard to find in that regard; we have to come to you and it's hard to come to us" (ACT 21SP). The shared caseload of ACT, coupled with perceptions of having to "start from the beginning" with every interaction, were voiced by the majority of both consumer and service provider participants as the most significant barriers to forming a therapeutic relationship.

To summarize, I found that lack of autonomy and not feeling listened to were aggravating factors that increased perceptions of coercion in the ACT treatment relationship. My findings also showed that the presence of embedded police officers shaped perceptions of reduced autonomy and personal agency for consumers and enhanced experiences of coercion. I also found that when consumers lacked agency and autonomy this sometimes led to resistance which in turn could result in service providers perceiving an increased need for police officer presence during interactions.

4.3.4. Treatment as Trauma: "Hospitalization saves lives. It also traumatizes people."

Almost all consumer participants shared stories of trauma associated with previous psychiatric treatment, and these experiences appeared to continue shaping how they perceived ACT treatment and influence how they engaged with ACT service providers. Consumers almost universally had experienced involuntary hospital-based treatment as traumatic. My data revealed descriptive accounts of individuals being

stripped naked, physically restrained, and placed in seclusion, feeling marginalized and belittled, and being forcibly administered medication. These accounts were common. The following provides an example:

It's their way or nothing when you're there. You just got to go with it and hopefully tomorrow will be a better day, right. . . . When they send you to the quiet room you feel like you're under the gun and that you're a bad person or something like that. . . . Resist and they'll throw you in . . . they'll force you to go into the room. . . Strip you too. (ACT 39C)

These experiences are important to consider in relation to my previously presented findings on power relationships in community treatment, and the potential threat of being recalled to hospital. Because most consumers had experienced hospital treatment as traumatic, the potential or "threat" of being recalled from Extended Leave back to hospital held significant power over them and increased their perceptions of coercion.

Some of my service providers also perceived the treatment system they worked within as carrying immense power and potential for harm. The following provides an example:

Yeah and how this impression that medications and Extended Leave and hospitalizations saves lives . . . sure, you know what, and other times it also traumatizes people to the point where they feel like they have no power and they also want to harm themselves. (ACT 11SP)

Consumers and service providers shared narratives emphasizing that hospital admissions in this setting were largely reserved for involuntarily committed consumers. Some consumers shared that previous attempts to seek preventative voluntary admission to hospital to forestall a crisis had almost never been successful and sometimes had been interpreted by hospital staff as manipulative behaviour. For the majority of my consumer participants, hospital was not perceived as a place to seek treatment but rather as a place where treatment was forced. The following data excerpt from a service provider interview supports this perception of consumers that the mental health treatment system in this setting has been built upon involuntary detention and forced treatment:

Our mental health system is not set up for people to be voluntarily accessing those services and if they do, they have extremely long waits to get service . . . if the system tells you, “you need to,” then you need to. (ACT 12SP)

This finding was important in part because ACT consumers are often characterized as “difficult to engage” and resistant to treatment. My findings showed that these characteristics were perceived as justifying the use of involuntary treatment such as Extended Leave. However, the perceived inaccessibility of *voluntary* treatment in this setting underscored a potential system gap that may result in missed opportunities for preventative and maintenance measures, leading to an over-reliance on involuntary treatment and crisis response interventions.

I also found that consumers perceived ACT interventions as having more potential to be traumatic and potentially coercive when closer in proximity to their bodies. More distal interventions, even if perceived as potentially coercive, were experienced in less negative terms. Interventions requiring a service provider to touch a consumer (e.g., medication administration or wound care), especially if such touching was initiated by the service provider without consultation or consent, were experienced negatively and as extremely intrusive by most consumers. My findings suggested that experiences of coercion were not associated solely with these interventions, but rather with the context in which they were delivered and by whom. I found that the development of a strong therapeutic relationship could reduce perceptions of coercion-associated interventions involving close proximity of service providers. For example, if a consumer were receiving an injection from a nurse whom they trusted and knew, this was usually perceived in more positive terms than receiving it from someone they did not know or had a challenging relationship with. Injections administered in the company of police were almost always perceived as being coercive and often as a source of trauma.

Service providers often referred to “trauma-informed care” and “trauma-informed practice” as clusters of interventions used to approach treatment for ACT consumers with trauma histories. However, I found that most of my service provider participants had little or no formal training in these concepts and that they referred more to a “lens” through which service providers implemented treatment interventions. Despite lacking this formal training, most service providers expressed a strong desire to use interventions that were respectful of consumers’ trauma histories, and often this involved

trying to enhance transparency and choice in treatment decisions. The following excerpt provides an example:

They've [ACT consumers] been traumatized by the system. I feel our [ACT] team works really hard at just trying to build rapport around anything. Like having the client initiate as much as possible. Like what they want our involvement to look like? So, talking about visit schedules . . . "can we start with like three times a week? Is morning or afternoon better for you? Is food security an issue for you?" Like, starting with normalizing our meeting; going for a cup of coffee, going for a walk, you know . . . (ACT 12SP)

Some service providers discussed specific interventions that they had found helpful in providing trauma-informed care and that they believed reduced perceptions of coercion in treatment. The following excerpt provides several examples of interventions that were commonly shared by service providers:

I think I have a good grasp on the trauma-informed piece too, which I think makes a huge difference. So, watching things like space, language, consistency, boundaries, being truthful and honest: "this is what I offer you, this is how I want to work with you, this is the outcome we're looking for." Kind of going from there and tell me "what worked in the past; what didn't work in the past with the [mental health] team? What do you think you can get from us [ACT team]?" Then they start going "well what do you mean what can I get from you?" Also, just looking at like "what do you like to do?" (ACT 14SP)

Service providers who spoke specifically about practicing from a trauma-informed perspective noted that the ACT model could sometimes promote interventions that were not aligned with trauma-informed care and that active effort was required to counteract these. For example, as noted earlier, the shared caseload model could result in care being provided by a number of different rotating service providers. Service providers and consumers shared that this could be confusing and contribute to inconsistent approaches and a lack of trust between consumers and their treatment team. The following excerpt provides an example:

If you're coming from a trauma-informed perspective also . . . you have all these random people [ACT service providers] knocking on your door and [they] may not

be [trauma] informed or may not even be [trauma] aware. . . . So, I mean coming from that trauma-informed perspective you want to really be aware of ways to engage. (ACT 11SP)

This excerpt touches on an issue I explored elsewhere, that some contacts between service providers and consumers could be experienced as “check-ins” with little purpose aside from “monitoring” a consumer.

In summary, many consumer participants shared previous treatment experiences that were sources of trauma, with particular emphasis on prior involuntary hospitalizations. Previous experiences of traumatic treatment shaped how consumers experienced ACT, especially in relation to the use of Extended Leave and the potential for involuntary recall back to hospital. Previous traumatic experiences with involuntary hospitalizations increased perceptions of coercion when consumers were reminded of the potential powers of this legislation. My findings also showed that the proximity of an intervention to a consumer’s body increased the potential that such interventions could be experienced as intrusive. I found that a therapeutic relationship and collaboration with a consumer prior to initiating interventions that brought a service provider in close proximity mitigated experiences of intrusion and coercion. I also found that service providers attempted to use trauma-informed care to reduce perceptions of coercion and improve the treatment experiences of consumers.

4.3.5. Surveillance and Privacy Issues: “It’s like they have a beacon on you.”

Almost all consumers perceived an increased level of surveillance and a reduction in privacy resulting from their treatment with ACT. Some consumers described experiences when treatment felt like being prey “hunted” by service providers. The following data excerpt provides an example of how some consumers perceived the assertive outreach features of ACT: “They hound you if you don’t take your shot and they’re after you. They knock on your door and they won’t leave you alone until you take your shot” (ACT 23C). Some consumers shared examples of staying in their suites for periods of days, believing that if they were to leave, they would encounter ACT service providers. Consumers expressed concerns when service providers were able to locate them away from their residences, and these experiences amplified concerns about being

under surveillance. Consumers provided examples of encountering ACT service providers at food security sites, pharmacies where they received daily opiate replacement therapy, or near supervised drug ingestion sites. Consumers experienced enhanced perceptions of surveillance and lack of privacy when service providers were able to find them at such locations and believed that these should be “treatment-free” settings.

Most consumers noted that within the small geographical boundaries of The Block, it was common to see ACT service providers on outreach, even if they were not looking for those consumers. These instances of contact, even if brief, were sometimes perceived by consumers as monitoring. In the words of one: “It’s like they have a beacon on you or something like that; they just kind of show up. You’re not always in the best mood, right” (ACT 39C). Observational fieldwork in the Met Community Building provided numerous examples where multiple staff from different ACT teams, including the embedded police officers, were seen entering common areas of that building at different times of the day, and sometimes even arriving in unison. These were documented in field notes as “waves” of service providers that I initially perceived as potentially inefficient service delivery. However, the emergent theme of heightened surveillance led to a re-analysis that consumers likely experienced these “waves” as enhanced monitoring within the building.

Consumers living in supported housing, SRO hotels, or other locations with on-site staffing reported perceptions that their activities were being monitored and relayed to ACT service providers by housing staff. Examples of information that were perceived as being shared between building staff and ACT included: medication adherence,⁸ conduct and behaviour in the building, guests who visited, substance use levels and risk-related behaviours, and perceived conflicts with neighbours or staff. My findings from service provider interviews confirmed that information sharing between housing providers and ACT service providers was common. Most ACT service providers viewed this form of information sharing as important because it supplemented their contacts with consumers and facilitated better “monitoring” of symptoms. Some also asserted that information sharing was reciprocal, with ACT service providers also sharing details and

⁸ Some supported housing options provided medication administration. This ranged from on-site housing staff dispensing medications to blister-packed medications held by staff that consumers would ask for.

updates with housing provider staff. ACT service providers who spoke about this information sharing viewed it as helping to foster relationships with housing providers and as an important component of treatment.

I also found that several consumers had privacy concerns related to ACT service providers having the ability to enter their residences. Several consumers spoke of instances where ACT service providers, including the embedded police officers, entered their suites when they were not home. Most of the consumers who shared these experiences perceived these instances as an invasion of their privacy. However, service providers who spoke about such instances described their actions as conducting “safety checks” to ensure the welfare of consumers. Such safety checks were usually conducted through the assistance of building staff, who used master keys to access suites.

In summary, most consumers perceived that they were subject to increased surveillance and decreased privacy through their enrollment in ACT. I found that consumer perceptions of surveillance and lack of privacy shaped attitudes towards ACT and represented a form of monitoring that usually was neither wanted nor consented to. While in themselves these concerns of increased surveillance and lack of privacy were not always tantamount to coercive practices, consumers almost always perceived them in negative terms.

4.3.6. Legislation and Formal Mechanisms of Control: “At the end of the day, they don’t have the choice.”

The BC Mental Health Act and its Extended Leave provisions were spoken about extensively by consumers and service providers in relation to how this legislation heightened the potential for coercive episodes of ACT treatment. Service providers often described a dialectic of simultaneously seeing both positive and negative aspects of this legislation. My analysis showed that for most of my service provider participants, embedded within this dialectic were assumptions that for most ACT consumers, some form of involuntary treatment was necessary. My consumer participants challenged these assumptions and almost universally denied any benefit to involuntary hospital detention or forced treatment. On the contrary, most consumers had experienced previous episodes of involuntary hospital admission or treatment as humiliating, traumatic, embarrassing, and contributing to their animosity and resistance toward the

overall treatment system, including their ACT team. The following data excerpt illustrates the context and how the Mental Health Act facilitated treatment but also generated resistance on the part of consumers:

I'd say it helps, but it also leads to resistance and I think, you know, I kind of have to speculate a little bit and try to imagine myself as somebody who's been on Extended Leave for a while and one of the common stories, I am sure you've heard it too, is just the people just feel like their autonomy has been stripped away. And autonomy is, that's a value I actually really respect people to have and if someone's on Extended Leave, how do you have a collaborative relationship with them? . . . You can have a collaborative conversation as much as possible, but at the end of the day, they don't have the choice. The doctor is going to decide what their medication is going to be. The doctor, the team will decide whether they're going back to hospital. They don't have that choice, so they have some room to work with it, but they've got to work within that really restricted thing. (ACT 10SP)

Some service providers reported that they perceived Extended Leave, especially in combination with the assertiveness and invasiveness of the ACT service delivery model, as creating a strong potential for social control. The following illustrates how these dynamics may be perceived by service providers:

I have always struggled with Extended Leave. I mean it really is intrusive. I mean I get the argument for it. . . . Definitely the Extended Leave piece is part of the social control. I mean it feeds into the social control thing. . . . Yeah, honestly I really feel like in terms of the case management piece, and even the Extended Leave piece, I mean we talk about being client-centred and wanting to work with clients on their goals, but it doesn't seem that way to me. It seems more like we are just trying to contain people so that they are not disruptive in the community, which limits people's choice. (ACT 18SP)

It is notable that this data excerpt refers to controlling disruptive behaviour through Extended Leave. Most of my service provider participants struggled with beliefs that this legislation was used to control behaviours, seeing that as distinct from using Extended Leave to compel treatment interventions. This finding linked with an earlier theme

whereby service providers struggled between identities as agents of social control and agents of change. Many service providers echoed the previous excerpt and voiced that BC's Mental Health Act, and its seemingly prolific use in ACT treatment, enhanced concerns about acting in the interest of social control. Consistent with this, most consumers experienced the legal leverage of Extended Leave to be coercive and saw little room for autonomous decision making within its provisions. One consumer described it in this way:

I feel like it . . . it imprisons people that have mental disorders into like this program [ACT] that they put you in, right. And you're like stuck in this program for the rest of your life type of thing. That's what it feels like. . . . Yeah, it is kind of horrible. (ACT 35C)

I found that consumer narratives about Extended Leave, and the Mental Health Act in general, often used terms that associated it with criminal justice system punishment such as being imprisoned. I also found that participants who had experiences with the criminal justice system, as either service providers or offenders, comparatively found the powers of the BC Mental Health Act to be more coercive and to have less accountability and independent oversight than the justice system. The following consumer provides a relevant perspective:

Personally, I would rather be in jail than in the psych ward a million times over. . . . I'd rather do four, five years in jail than one year in the psych ward personally. . . . It sucks, yeah. Cause in jail . . . even if they're on Extended Leave and they're supposed to give medication, they'll ask you if you want it, "do you want your medication?" "No thanks." "No problem, we don't have a problem, sorry sir" and they'll back off right there and they won't say another word. But in the psych ward, it's like we're forced sometimes, "we'll pin you to a bed and stick it in you if you don't . . ." (ACT 47C)

Some service providers perceived that Extended Leave also had the potential to be used as a treatment "shortcut" by less-skillful clinicians. In other words, rather than using more gentle and skillful forms of persuasion that necessitated the development of a strong therapeutic relationship, Extended Leave provisions could be used to force

treatment quickly and without the consent of consumers. The following data excerpt provides an example:

Simply because we are using it as shortcut. We are not investing in client–clinician relationship building. We have this power. We are getting these guys from the hospital or wherever we get [them] from. Well they’re on Extended Leave, a clear indication that they must do as part of their Form 20.⁹ That you have to see your psychiatrist, you have to get your injection, and you have to do this, otherwise you end up in hospital. . . . Clients know that the alternative is police coming and taking them down and taking them to hospital. So rather than go through that humiliation, they will go with what we say. . . . I think it [is] one of the worst forms of coercive interventions we have in the mental health system in British Columbia. (ACT 19SP)

In the previous data excerpt, this service provider alluded to the implicit “threat” that consumers knew existed when on Extended Leave: that they could be recalled to hospital if they failed to comply with their treatment conditions. Consistent with this theme, a number of my service provider participants used terms such as “paper tiger” to describe how it was more effective in making consumers aware of the powers of this legislation than in actually exercising them. The following excerpt provides context:

It doesn’t give me nearly the amount of control as the average person would think it would give you over these clients because it’s a paper tiger. . . . So what does it do? . . . Even if I recall you, the chance that you’ll still be in hospital a week later after that recall is like maybe 10%. . . . So what did that achieve? . . . I have one hammer in that whole toolbox, that’s it. And once I’ve used it, I’ve used it, and then you’re back out in the exact same position you were twenty-four to forty-eight hours later . . . but we’re actually usually in a worse place because you’re pissed at me because I’ve sent you to the hospital. (ACT 1SP)

For many of my service provider and consumer participants, the control of Extended Leave was not dependent on its power being exercised (recall to hospital); rather, its power existed as the ever-present potential of that possibility. As such, the

⁹ The Form 20 under the BC Mental Health Act stipulates the conditions of Extended Leave and transfers the care of a consumer to a community psychiatrist to monitor compliance. Conditions of a Form 20 may include taking medications prescribed by that psychiatrist.

coercive powers of Extended Leave went far beyond the formal mechanisms it facilitated, and threats of its use could be leveraged to compel and coerce a range of control over consumers without its actual execution. A consumer excerpt provides more context for this phenomenon: “Seems like more like a fear tactic, you know. Like if you don’t do this [receive medication] you’re gonna be [hospitalized]. . . . It’s more like threats and fear. That’s what I find most. (ACT 46C)

To summarize, my findings showed that the formal legislative powers of BC’s Mental Health Act over involuntary treatment processes such as Extended Leave were often experienced as coercive by both service providers and consumers. For my consumer participants, the recall process to hospital was often described using terms such as “humiliation,” “embarrassment,” and “trauma.” However, my findings also showed that the power of this legislation was not limited to situations where it was exercised but also had an effect in episodes of care where the potential of its use existed. In other words, persuasive techniques of service providers that drew attention to the potential use of this legislation were also experienced as coercive, in part due to consumers’ previous traumatic experiences of involuntary hospital admissions. My results also illuminated service provider concerns that the expansive powers of this legislation could contribute to its use as an unskilled treatment “shortcut” by fellow clinicians, which stressed the potential lack of accountability and oversight in the use of this legislation.

4.4. Interventions Reducing Feelings of Coercion

While the above-noted dynamics illustrated diverse ways in which service providers and consumers experienced and perceived coercion in relation to ACT, my findings also stressed the importance of interventions and strategies that may have reduced or counteracted feelings of coercion. I present these under three themes: the therapeutic relationship and increasing autonomy; reducing medication contacts; and the role of incentives.

4.4.1. The Therapeutic Relationship and Increasing Autonomy: “There’s a respectful and a humane approach.”

Almost all consumers and service providers discussed the power of an effective therapeutic relationship and how mutual trust and understanding between service providers and consumers were tools that facilitated progress towards mental wellness and recovery. The establishment of a therapeutic relationship was shown to increase relationship capital for service providers and reduce consumer perceptions of coercion associated with ACT treatment.

Most service providers spoke about structural aspects of the ACT model (shared caseload, a clientele considered “difficult” to treat, and seven-day-a-week multidisciplinary staffing) that created barriers to forming therapeutic bonds with consumers. This could be contrasted with traditional case management, whereby a single service provider would be the primary contact person for a given consumer and a therapeutic bond could be readily fostered between the consumer and provider. My findings suggested that ACT consumers were asked to form a therapeutic relationship with the model itself or the entire team rather than an individual clinician and to extend this relationship and trust to whichever ACT service provider had contact with them on a given day. Most service providers reported that the structural elements that made ACT service delivery unique and effective also necessitated a conscious effort toward developing and maintaining a trusting therapeutic relationship to counteract these structural limitations. However, my findings revealed that most service providers perceived that significant benefits would likely result from making this effort. The following excerpt describes several interventions seen to facilitate improved engagement with consumers, including forming a therapeutic relationship prior to full ACT enrollment, as well as making efforts to increase transparency and consumer autonomy:

So, then I made this decision . . . [what] we should do is start to engage with him now prior to taking him . . . completely on the team. Prior to [ACT] administering medications and that, doing it with this other community mental health team and being quite transparent and . . . giving him some autonomy. I mean, obviously you can’t have full autonomy like, but “no I don’t want my injection,” but “okay, what time works for you?” You know, “we’d like to come by,” so giving them some information and informing them. Transparency I think is a good thing, and

so from there he's been taking his injections and has been engaging with us. And so, yeah, there's a respectful and a humane approach that I think sometimes clients don't necessarily receive. (ACT 11SP)

Several service providers shared examples of building a therapeutic relationship through interactions that did not focus explicitly on treatment, in order to build familiarity and trust. The following data excerpt provides context:

I guess I can speak to the approach I would take is gradual “warming up” in terms of meeting, suggesting we go for coffee, or just go for a walk and talk—nothing about medication, talk nothing about treatment per se, but just trying to establish a basic rapport of person to person is what I find most effective myself. (ACT 15SP)

Consumers also spoke about the value of these “non-treatment” contacts and interactions and perceived them as normalizing their relationships with service providers. Several consumers and service providers also spoke about an annual ACT wilderness camping trip and the overall therapeutic value generated by that experience. Participants explained that at least once per year, a small group of service providers and consumers embarked on a camping trip, and that the limited spaces for both service providers and consumers were coveted. This camping trip often involved an intensive period of time together between service providers and consumers that was experienced as separate from formal treatment interventions. The following excerpt from a consumer reveals the power of this camping trip for them:

So, I went on it and it was good to get away from [the Met Community Building] for the weekend. And going out there, going for walks, being alone. Having fun, laughing—that was a big part. . . . It's like everything is released. It's just like, ah, you could just relax and have fun. (ACT 30C)

However, my findings showed that such “non-treatment” contacts did not need to be as elaborate or time consuming as a wilderness camping trip. Other examples from my data included activities such as social groups, exercise outings, and less-structured undertakings—for example, service providers and consumers meeting for coffee or going for a walk together. Such activities were associated with building relationship capital and increasing overall satisfaction with ACT treatment for consumers, even if

such treatment was still governed by the provisions of Extended Leave. My findings revealed that once such relationship capital was established, interventions that previously had been experienced as coercive (such as the administration of medication) were perceived more positively by consumers within the context of being engaged in by a trusted service provider.

My analysis also underscored the importance of peer support specialists within the police-embedded ACT model and how relationships with peer support improved overall treatment satisfaction for consumers. Peer support specialists are individuals with lived experience of mental illness who work as ACT team service providers. Although the role of peer support was not prominent in the experiences of service providers, consumers experienced them as a key connection with their ACT team, overwhelmingly positive, and improving overall satisfaction with ACT treatment. Some consumers noted that peer support specialists were not centrally involved in other treatment interventions (particularly medications), and this element of separation was a key component to building a positive relationship with them, as seen in the following data excerpt:

Yeah, not a nurse and I don't get the shot from him, and I can let him read my journal, and he won't judge me, and he still loves me for who I am and for the fight that I'm struggling with right now. (ACT 23C)

This description also stresses the empathy and trust experienced by this consumer in their relationship with this peer support specialist. Several consumers noted that the therapeutic bond felt with peer support workers was more similar to a friendship than to conventional treatment: "It's a different kind of thing. . . . It's one on one and she's like a counsellor, and sort of a friend" (ACT 46C). Peer support specialists were often referred to with terms such as "love," "like," "trust," "friend," and "family." The following quote from a consumer provides a good example of experiences I heard:

You know where she's [peer support specialist] been and what she's been through. And you got to have people there that are the same as you, you know, right? You don't want people that never said the word "shit," and never [been] hurt. You got to have people that you can relate to. (ACT 45C)

This excerpt is important because it notes several characteristics of the peer support specialist that cultivated this trusting relationship, such as their shared journey with

mental illness and treatment. The excerpt is also striking because of the consumer's emphasis on being "hurt" as a component of having a mental illness, and as an attribute strengthening the relational connection between them. While subtle in this particular excerpt, the traumas and stigma experienced by consumers with mental illness were evident.

To summarize, my findings emphasized the importance of a therapeutic relationship between consumers and service providers in the ACT model. Interventions such as activity groups, camping, and the involvement of peer support all appeared to increase treatment satisfaction for consumers. My findings also showed that when relationship capital was established, the same intervention that had previously been experienced as coercive could be perceived in more positive terms.

4.4.2. Reducing Medication Contacts: "Every three weeks I get my shot, which is better than every week because I hated that."

I found that treatment interactions between service providers and consumers that were specifically focused on the administration of medication (whether oral or injectable) were viewed more negatively and as more likely to be coercive than other contacts. Both consumers and service providers shared that non-medication-related contacts tended to be more focused on consumer-identified needs. For consumers, such non-medication contacts increased perceptions of personal agency in overall treatment experiences.

I elicited an interesting finding that while most consumers preferred oral medications to injectable forms, this was primarily when consumers were able to independently ingest the medication. I found that daily witnessed ingestion (DWI) of oral medications administered by ACT service providers was a common treatment practice, often in cases where medication adherence was questioned. DWI practices were often experienced negatively by both consumers and service providers—specifically, they were perceived as "rushed," inflexibly scheduled, and necessarily increasing the percentage of medication-related contacts in a consumer's overall care. Some consumers shared that DWI obligated them to be in a specific place at a specific time every day of the week. Consumers also revealed that they were expected to be at that location for a large window of time to accommodate the schedules of ACT service providers commuting from other locations. I also found this DWI process necessitated

that the consumer not only ingest the medication but also prove they had swallowed it (e.g., by showing an empty mouth)—a process they often experienced as belittling and paternalistic.

For service providers, DWI administration of oral medications was experienced negatively because of the amount of workload it created and the structural limitations that resulted from staff scheduling. I learned that the police-embedded ACT teams being studied operated daily until 8pm, meaning that service providers had to administer nighttime medications earlier than consumers often wish to take them. Service providers described rushing to these appointments at the end of their day and wanting them completed as quickly as possible. Both service providers and consumers described these DWI oral medication contacts as feeling rushed and prone to the use of coercive techniques to facilitate expedient compliance by consumers. The following excerpt from a service provider provides context:

Someone might need the clozapine medication in the evening, and we only work until eight. So, we've got to get there at the latest probably seven, and so there is not really that much room for flexibility on that end of the day. (ACT 15SP)

When this service provider spoke about flexibility, they were referring to requests from consumers to change the timing of their DWI administration. Those service providers and consumers who spoke about evening DWI often cited the powerful sedating effect of medications as the reason consumers preferred to ingest them later in the evening. The following excerpt from a consumer provides an example: "They were giving me some pills . . . in the building. . . . I can't remember what it was called, man, but it made me fall asleep real fast. Like knock you out" (ACT 35C). Some consumers spoke about potential solutions that could reduce perceptions of coercion related to DWI of oral medications. These included having medication delivered to a consumer by a pharmacy rather than by ACT service providers, consumers attending a pharmacy with extended hours for DWI, or having a medication administration program within their building. My findings suggested that these solutions would also provide benefit by decreasing the proportion of medication-focused contacts between ACT service providers and consumers.

Although most consumers spoke about injectable antipsychotic medications in negative terms, the frequency of administration appeared to have a powerful influence

on overall perceptions of coercion and satisfaction with ACT treatment. Most consumers shared that longer periods between the administration of injectable medications decreased perceptions of coercion related to ACT treatment. Although consumers still often perceived the administration of the injection itself as negative, decreased frequency of administration facilitated a higher number of non-medication contacts with service providers between medication administration and improved the overall treatment experience. The following excerpt provides an example:

Every three weeks I get my shot, which is better than every week because I hated that. It was just torture on me. So, I finally got them to move it to three weeks and I'm okay with it now. I can handle it now. Every week I couldn't handle it. It was freaking me out. (ACT 23C)

I noted that this excerpt was also important because the consumer felt that their concerns were heard and responded to. Service provider interviews revealed that such alterations in frequency usually necessitated changing to a different form of injectable medication or increasing the administered dose. Most service providers also reported that decreasing the frequency of administration for injectable medications improved overall treatment experiences with consumers. Several service providers perceived increased personal risk of violence when administering injectable medications due to their close proximity to consumers and the perceived potential for resistance. Some service providers reported feeling stress, anxiety, and trepidation in having to administer medications to a consumer who was resisting, or likely to resist, even when in the presence of a police officer. From the perspective of some service providers, having the option of longer-acting medications (with reduced administration frequency) improved the potential for collaboration with consumers and the ability to respond positively to their requests for “less medication” while still maintaining a therapeutic dose capable of treating corresponding symptoms. The following description provides an example of the importance of reducing the frequency of injections:

Yeah, less injections. . . . And hopefully it's less negative interactions with the client as well because they don't like it. So rather than give it to them two times every month, try and only giving it to them once a month because they don't like it at all. (ACT 1SP)

In summary, my findings showed that for both consumers and service providers, interventions that reduced the number of medication-related contacts decreased overall perceptions of coercive treatment and increased overall treatment satisfaction. While medication-related contacts were still often experienced as sources of potential coercion, treatment experiences for both service providers and consumers were improved by reducing the frequency of their occurrence or having medications administered by an external provider (i.e., a pharmacy).

4.4.3. The Role of Incentives: “I’ll give you a pack of smokes if you take this injection.”

Almost all service providers reported that they saw benefit in providing incentives to consumers as a component of ACT treatment. Some viewed the provision of incentives as a “softer” or “friendlier” form of coercion (or persuasion), which could prevent the use of more overtly coercive interventions (such as bringing a police officer). Common examples provided by service providers included interventions such as taking a client out for coffee or food, shopping for groceries, facilitating computer or telephone use, or providing items such as taxi vouchers. Often such incentives were linked to a direct treatment goal, such as taking a consumer for food after going to a clinic for blood work. However, both service providers and consumers also shared examples where incentives were used without a direct exchange for something else. In other words, my results showed that incentives were sometimes used as standalone interventions, often with the intention of improving therapeutic bonds.

For most service providers, incentives were perceived as important tools for building connections with consumers and normalizing the overall treatment experience. Although there appeared to be standardized incentive options (food, cigarettes, taxi vouchers), my findings suggested variation between the five ACT teams from which participants were drawn with regards to *what* was used and *when*. I also found examples where service providers would use their own funds (rather than funds from their employer) to pay for incentives. I viewed this as an indication of the power and perceived value of such incentives for service providers. These examples were usually in cases where the incentive the service provider intended to use was not “officially” approved for use by their team. Examples included using cigarettes or exceeding a capped amount for food that had been set as part of the consumer’s care plan (e.g., spending \$20

instead of \$15). My data also showed that family members of consumers were sometimes involved in the provision of incentives. For example, the family members had given service providers a certain amount of money for them to use as general incentives or towards a specific goal, such as motivating better hygiene. Funding from family members also allowed for the use of incentives that were outside the financial capacity of service providers or their teams—for example, linking treatment goals with a carton of cigarettes or the purchase of an item such as a television.

Some consumers shared that if a potentially negative intervention (for example, an injection) was paired with something viewed as pleasurable (such as food), this could reduce negative feelings towards that intervention and overall treatment. Even if the intervention were still viewed as negative, many consumers experienced increased autonomy, feeling that they were making a “choice” to take the incentive in exchange for the intervention. The following description is from a consumer who looked forward to their scheduled injection because their ACT team paired it with shopping for clothes and food, which they valued:

So, like, it's [the injection process] starting to get better. I'm not minding that. I don't mind. If I have to get a shot once a month to get a couple [of] groceries in my house. They're gonna take me clothes shopping 'cause I have no clothes. . . . I need clothes and some shoes, some running shoes. And, so, tomorrow I get to go do that too. (ACT 33C)

The previous excerpt is important because it shows that the pairing of an incentive that was known and expected by a consumer with the injection had led them to look forward to the medication administration date. However, I also found that a minority of service providers perceived incentives as coercive and representing the antithesis of collaborative treatment. The following explanation details this minority view:

Food is bait. We're using food just to get access to them, to make work easier for us. They're poor, they're hungry, it's the easiest thing to do. . . . They are marginalized. So, we are not addressing the real issues they're dealing with, and then we [service providers] have the money because we have petty cash. So, I can take them for food and still call it treatment. I find it unethical. We are not addressing the food issue; we are not addressing the poverty issue. (ACT 18SP)

This excerpt articulates the power that these incentives held for ACT consumers. As the previous service provider stressed, the marginalization, poverty, and lack of food security commonly experienced by ACT consumers increased the potential power of incentives such as food, clothing, or cigarettes. As such, even though consumers predominantly experienced these incentives as valued and positive aspects of their relationships with service providers, some service providers critiqued the power imbalance from which they were provided and the motives for which they were used.

Similarly, I also found that some consumers noted incentives were more meaningful when provided within the context of a trusting relationship. If care was not taken in the provision of incentives, they could be interpreted as bribery or coercion, as seen in the following example:

They'll bribe me to do the injection. Like they bribed me with a pack of smokes last time. They're like, "I'll give you a pack of smokes if you take this injection." . . . Yeah, like it's weird, right? (ACT 35C)

In summary, the use of incentives by service providers in the context of a trusting relationship could increase perceptions of autonomy and decrease perceptions of coercion for consumers. However, my results also showed that the thoughtful use of incentives was necessary to ensure they were not interpreted as bribery. Further, some service providers noted that the desirability of incentives for consumers called attention to the extreme marginalization they face and increased the potential coercive power held by service providers.

4.5. Discussion

I undertook this qualitative research to gain a better understanding of ACT teams operating in a BC municipality that have been modified through the embedding of police officers. Although the ACT model itself has been the subject of considerable research, this modification is an underexplored area of inquiry. Through this research, I sought to explore the issue of coercion within this ACT model with embedded police officers, using a qualitative investigation of the experiences of service providers and consumers. I have presented my findings under two large themes: (1) experiences emphasizing perceptions of coercion and (2) experiences of interventions reducing perceptions of

coercion. My findings are important, in part because of the centrality of the embedded police officers within narratives about practices deemed coercive by both service providers and consumers. My research results differ from previous research because they emphasize perceptions of coercion and therefore point to the need for further investigation and caution in the use of this treatment modification. My findings are also important because they identify interventions that service providers could employ to decrease perceptions of coercion and enhance consumer satisfaction with overall ACT treatment. My findings illustrate that reducing perceptions of coercion could increase service provider satisfaction with their work through internal identification as agents of change rather than as agents of social control.

Although coercion in ACT has been explored by previous qualitative researchers, most of those studies have been limited to a single data source, such as interviews or focus groups with service providers. I assert that this approach is limited or even problematic because my findings have illustrated that how an intervention is experienced, and whether it is considered coercive, is dependent on the individual(s) providing the intervention, the intervention itself, and the person receiving it. My methods facilitated the use of three data sources to better describe, explain, and understand such interventions. These methods allowed me to link the perspectives of service providers using such interventions, consumers receiving them, and researcher observations of their use. To my knowledge, this is the first study to utilize such wraparound methods to directly investigate the topic of coercion in ACT, and I believe that it facilitated a robust understanding of the dialectic between restriction and autonomy.

4.5.1. Fit with Previous Literature

Although I found the body of ACT literature to be dominated by quantitative methods, the issue of coercion has received substantial focus as a proportion of the qualitative research reviewed. This may be due to the prowess of qualitative methods in drawing out individuals' experiences related to this complex topic, or recognition from researchers that coercion is a challenging concept to quantify (Gomory, 1998).

Loftus and colleagues (2018) noted that consumers can simultaneously experience autonomy and restriction from ACT treatment, and my results also underscored this complex dialectic. Previous research has also found results

comparable to my findings that the transitional period immediately after enrollment in ACT can be a time of heightened perceptions of coercion for consumers (Thøgersen et al., 2010). My results point to the lack of a therapeutic relationship in the initial stages of enrollment as a primary reason for these increased perceptions of coercion. Consistent with the findings of Lamberti and colleagues (2014) and Thøgersen and colleagues (2010), I found that perceptions of coercion for consumers were more pronounced when autonomy and personal agency to make decisions or be involved in decision making were experienced as limited. My research also produced findings consistent with those of Krupa and colleagues (2005), who found that experiences of coercion were often related to instances when consumers perceived that they were not listened to and that their opinions and input were not valued by service providers. My findings also build on previous research of Watts and Preibe (2002), who identified that interventions bringing service providers in closer proximity to consumers were more likely to be interpreted as coercive than more distal interventions. Also consistent with previous research (see Appelbaum & LeMelle, 2007, 2008; Krupa et al., 2005; Wild, 2006), my findings show that the existence of a therapeutic relationship can be a mediating factor that reduces perceptions of coercion for consumers.

Although positive impacts of including peer support within the ACT model have been explored by previous researchers, the primary focus of those studies has been on increasing social inclusion and strengthening treatment bonds for consumers (Baier et al., 2013; Bromley et al., 2013; Wakefield et al., 2011). I was unable to find reference in the ACT literature to peer support interventions mitigating perceptions of coercion to the degree presented in my results, and I therefore believe that my findings are likely unique in this area. I also note that although previous research has found that the inclusion of peer support workers in ACT can enhance recovery orientation and produce positive outcomes (Baier et al., 2013; Bromley et al., 2013; Wakefield et al., 2011), there are often barriers that prevent ACT teams from including peer support roles. For example, recruitment and hiring struggles, as well as structural barriers within the predominantly unionized healthcare industry contribute to the underutilization of peer support workers in the ACT model (Wakefield et al., 2011). My findings are important within the context of the existing literature because they point to additional benefits related to decreased perceptions of coercion resulting from including peer support within the ACT model that may not have been previously considered by administrators and policy makers. This

topic should be explored in future qualitative research with ACT service providers and consumers.

I found a strong theme of coercion related to the BC Mental Health Act and its Extended Leave provisions, which mandate involuntary community treatment in this setting. This is an important feature of the current study, as previous ACT research on CTOs and other forms of legal leverage mandating treatment has shown less emphasis on coercion (for examples, see Lamberti et al., 2014; Lofthus et al., 2016). My findings highlight that the use of Extended Leave conditions (or threats of their use), coupled with consumers' previous experiences of involuntary hospitalizations, enhanced the potential that interventions associated with this legislation would be experienced as coercive by consumers. It is important to consider my findings in this area within the context of there being an absence of research supporting involuntary treatment as more effective than voluntary methods (Kisely et al., 2017). My results should also be considered within the context of a recent evaluation of involuntary hospital treatment in BC, which found procedural concerns, infringement of consumer rights, and lack of autonomous oversight associated with involuntary hospital admissions and forced treatment (Office of the Ombudsperson, 2019). Although that report focused on hospital treatment and did not broaden its analysis to the use of Extended Leave provisions, my findings underscore that independent scrutiny should be extended to community-based involuntary treatment in BC.

While ACT research is generally lacking in examples of partnerships with criminal justice system agencies, I was able to find examples from the emerging ForACT literature (Kelly et al., 2016, 2017; Lamberti et al., 2017; Landess & Holoyda, 2017; Smith et al., 2010). However, examples of criminal justice system collaboration, if even specified, appear limited to roles such as probation, parole, corrections officers, and criminal courts rather than policing (see Kelly et al., 2017; Landess & Holoyda, 2017). The only direct reference to the phenomenon of embedding police officers in ACT that I could find was a report commissioned by the municipal police department in Victoria, Canada to assess a recently created police-embedded ACT model in that city. However, findings from that report overwhelmingly endorsed the inclusion of police and called for expansion of the model, and the report is virtually devoid of findings of coercion (Costigan & Woodin, 2018). Conversely, my findings emphasized perceptions of coercion, and the embedded police officers on these teams were often central to such

experiences. I believe that my unique recruitment methods likely provided me with access to a cohort of consumers whose voice has been absent from previous qualitative research examining coercion in the ACT model. I note that other researchers have cited limitations to their findings related to potential selection bias for consumers who are more engaged in services (for examples, see Cuddeback et al., 2011; Krupa et al., 2005; Milbourn et al., 2014; Thøgersen et al., 2010; Watts & Priebe, 2002). My recruitment methods address this limitation, and my findings suggest both that this cohort of less-engaged ACT consumers may be more resisting of services and that their perceptions of coercion may be heightened compared with more-engaged consumers. The differences between my findings and previous research, in combination with the limitations of previous recruitment methods, speak to the need for future researchers to replicate my methods and recruit independently of ACT service providers.

4.5.2. Research Strengths and Limitations

There are several strengths to my research, including my recruitment methods, data-generating methods, and approach to analysis. My recruitment methods facilitated access to a sample of consumers independent of service provider screening. Although it would have been more expedient to recruit through the assistance of ACT service providers, I believe this would have allowed those service providers to gatekeep the sample and create selection bias. Given that ACT teams service a population that by definition is difficult to engage, it is understandable that most previous researchers have relied upon the most convenient and efficient methods for recruitment. My methods were likely more time consuming and often necessitated outreach to meet consumers “where they were at.” I find it notable that these methods are also a hallmark of ACT treatment to facilitate engagement with this population. Therefore, while differences that separate my findings from previous research with regards to coercion may be a product of my setting, it is also plausible that they are an indication that I have accessed a group of voices largely absent from previous research. However, this point should not overshadow the centrality of embedded police officers in my findings; instead, it reinforces the need for future research in this area.

My data-generating methods are also a strength. Through conducting a large number of in-depth interviews with service providers and consumers as well as focused ethnographic fieldwork consisting of observations and informal interviews, I was able to

triangulate data and present a robust contextual understanding of the phenomenon under study. The breadth of these data also allowed me to reach the data saturation requirements of grounded theory ethnography analysis and therefore enhanced the trustworthiness of my results (Noble & Smith, 2015). Also contributing to trustworthiness was my use of a “data near” approach (Sandelowski, 2010, 2011) through which large blocks of participant quotes are presented such that interpretation by the reader is possible rather than reliance on researcher-derived analysis alone. My analysis process was also comprehensive and included collaboration with two ACT consumers as a form of member checking, to inform analytic direction and to validate my coding framework.

My research also has limitations. Firstly, I have made no attempt to assess the fidelity of these ACT teams. I conducted my analysis under the assumption that the internal assessment of high fidelity made by program administrators is correct. This limitation is important to consider within the context that the ACT model forms an anchor for my investigation of how the embedding of officers within mental health treatment shapes the experiences of service providers and consumers. If the teams being researched are not high in fidelity, my linkages to the ACT literature become tenuous. Secondly, my recruitment methods may have led to a biased sample of consumers because my recruitment was primarily through ongoing BCCSU prospective cohort research. With this recruitment strategy, I may have over-sampled consumers with substance use histories. Although this is a potential limitation, I note that previous ACT research has found high prevalence rates of substance use among ACT consumers in general (Bromley et al., 2017; McGrew et al., 2003; Meisler et al., 1997; Rosenheck & Dennis, 2001), and that my findings from interviews with ACT service providers suggest high rates of substance use amongst consumers in this setting.

4.5.3. Research Implications and Recommendations

My study’s implications are clear in identifying interventions and structural features of a police-embedded ACT model that can either aggravate or mitigate experiences of coercion for both service providers and consumers. My findings therefore provide a roadmap for clinicians, administrators, and policy makers with regards to practices that can be modified to reduce the potential coerciveness of ACT and increase treatment engagement by consumers.

My results show that the inclusion of peer support within the ACT model can increase overall treatment satisfaction, increase connection between consumers and their treatment team, and mitigate perceptions of coercion. These findings not only call for future research in this area but also make a strong argument for other jurisdictions without peer support workers in their ACT teams to consider this benefit in their staffing allocation.

My findings also have implications for policy makers. I found strong themes of coercion related to involuntary treatment mandated through the legislative powers of Extended Leave (CTOs). I also found that some consumers experienced police-embedded ACT treatment within this legislative context as being more restrictive and oppressive than criminal justice punishments. These themes are important given the lack of evidence that involuntary treatment provides better health outcomes than voluntary treatment (Heun et al., 2016; Kisely et al., 2017; Rugkåsa, 2016). Given my findings associating trauma and coercion with involuntary hospital treatment as well as experiences of Extended Leave, I critique the use of these methods in the absence of sound research substantiating their benefits. I note that many of the assumptions that inherently justify the use of involuntary treatment simply have not been demonstrated but remain strongly held by service providers. Until or unless such assumptions are shown to be correct, the trauma and coercion associated with mandated treatment remain unjustified.

4.5.4. Conclusion

My findings diverge from previous qualitative research by more strongly emphasizing that both service providers and consumers experience coercion related to ACT treatment. Experiences of coercion were found to be associated with structural elements of the ACT model, the formal legislation that governs involuntary treatment, and the embedding of police officers within these ACT teams. My findings call for caution in the use and expansion of this police-embedded ACT model, due to concerns that this modification necessarily increases experiences of coercion for both service providers and consumers. My findings clearly point to the need for independent investigation and oversight of the use of Extended Leave provisions in BC, to ensure that procedural safeguards are in place to prevent this legislation from being used as a mechanism of social control.

Chapter 5. Housing and Homelessness

Abstract

Background: Assertive Community Treatment (ACT) is regarded as being at the forefront of evidence-based psychiatric interventions for consumers with severe mental illness, with research showing that the model can reduce hospital use for its target population. ACT consumers are recognized as having complex psychiatric and psychosocial needs, and modifications to the ACT model have targeted outcomes beyond hospitalization rates, in domains such as substance use, criminal recidivism, and homelessness. Although ACT has been acknowledged for its ability to provide continuity of treatment for even precariously housed and homeless consumers, improved housing outcomes themselves are more prevalent in research pairing ACT with evidence-based interventions such as Housing First, a low-barrier approach to care that endorses housing as a basic human right and prerequisite for health. The British Columbia municipality within which I conducted this research is characterized by its high cost of living, limited rental stock, and inadequate income assistance rates, which have contributed to a “housing crisis” that limits residential options for marginalized populations such as ACT consumers. My research seeks to identify how service provider and consumer experiences are shaped by a police-embedded ACT model operating within the environmental context of this housing crisis. **Methods:** I collected data through 47 in-depth qualitative interviews with ACT service providers (N = 23) and consumers (N = 24), as well as targeted ethnographic fieldwork consisting of informal interviews and observational fieldwork. Grounded theory ethnography methods informed my data collection and analysis. **Findings:** My findings show that homelessness and housing instability create barriers to effective ACT treatment and impair mental wellness and recovery potential for high-needs consumers. My results also indicate that stigma, misguided social policies, and complicated bureaucratic processes combine to create system-level complexities and barriers that exclude ACT consumers from permanent supported housing options that might improve their treatment trajectories. **Conclusions:** System-level prioritization of ACT consumers is necessary to counteract the multiple barriers that prevent this population from securing permanent supported housing options.

5.1. Introduction

The overarching intent of this research was to examine how the phenomenon of embedding police officers in the ACT model shaped treatment experiences and health outcomes. However, during the course of data collection, a dominant theme related to housing and its association with ACT service delivery emerged as central, despite having minimal explicit connection to the unique police embeddedness phenomenon of these teams. Consistent with my inductive research methods, I pursued and presented this dominant theme because of its importance to participants, despite the lack of an unambiguous connection with the overarching objectives of this research.

The ACT model emerged over 40 years ago in the United States as a response to a “revolving door” phenomenon of repeat hospitalizations for a subset of deinstitutionalized consumers with “severe” mental illness¹⁰ (Bond & Drake, 2015; Cuddeback et al., 2013; Stein & Santos, 1998; Stein & Test, 1980; Weisbrod et al., 1980). After being the focus of decades of rigorous peer-reviewed research, the ACT model now stands at the pinnacle of evidence-based interventions for this population (Bond & Drake, 2015). The ACT model has proliferated around the world and has been adapted to meet the needs of differing geographic contexts, changing populations, and varying healthcare systems (Baier et al., 2013; Deci et al., 1995; Salyers & Bond, 2009; van Dijk et al., 2007; Zavrashvili et al., 2010).

Although ACT is demonstrated to be a flexible treatment model that can be adapted and modified to respond to evolving healthcare needs, key features have been standardized through fidelity tools measuring adherence to an “ideal” ACT model. High-fidelity ACT teams are characterized by features such as multidisciplinary staffing, low client-to-clinician ratios, frequent contact with consumers through outreach, and 24/7 service delivery (Bond & Drake, 2015; Bond et al., 2001; Cuddeback & Morrissey, 2011; Dixon et al., 1997; Morrissey et al., 2007; Salyers et al., 2013; Stein & Test, 1980). Research has shown that maintaining high fidelity is one of the best predictors of successful outcomes, particularly reductions in hospital use (Bond & Drake, 2015; Bond

¹⁰ The term “severe” mental illness distinguishes ACT consumers from others with serious and persistent mental illness. Severe refers to a high degree of prolonged functional impairment, or disability, that can co-occur for a small number of individuals diagnosed with a mental illness (Cuddeback & Morrissey, 2011; Morrissey et al., 2007; Rollins et al., 2010).

et al., 2001). Measuring fidelity has become an important component of ACT research because it allows comparisons of outcomes between studies where ACT team structure and interventions can be considered consistent across settings (Teague et al., 1998).

ACT consumers are often characterized by attributes such as social and economic marginalization (Chen & Herman, 2012; Estroff, 1981), substance use (Bromley et al., 2015), homelessness or housing instability (Wakefield et al., 2011), primary care (medical) comorbidities (Morrissey et al., 2007), frequent hospitalizations (Bond & Drake, 2015), criminal justice system involvement (Cuddeback et al., 2013; Watts & Priebe, 2002), and histories of treatment disengagement (Bond & Drake, 2015; Krupa et al., 2005; Pettersen et al., 2014). Because of the prominent financial cost of providing full-fidelity ACT services, enrollment is usually reserved for a subset of consumers with severe mental illness who have disengaged from, or “failed,” traditional community psychiatric treatment and who are frequent users of expensive urgent care services (Chandler & Spicer, 2002; Clark, 1997; Latimer, 1999, 2005). Although ACT is sometimes critiqued for focusing on pharmacological interventions (Kidd et al., 2010; Moser, 2007), recognition of benefits from incorporating principles of psychosocial rehabilitation have increased service delivery emphasis on domains such as improving activities of daily living, budgeting, housing, vocational rehabilitation, recreation, and overall social inclusion (Bond et al., 2001; Coldwell & Bender, 2007; Cuddeback et al., 2013; Dixon, 2000; Killaspy et al., 2009; Meisler et al., 1997; Monroe-DeVita et al., 2011; Wright-Berryman et al., 2011).

Adequate housing (or lack thereof) for consumers with mental illness has been an important issue in psychiatric care since the deinstitutionalization process began (Richter & Hoffmann, 2017). Stigma, economic marginalization, and complex unmet psychosocial needs experienced by people with severe mental illness have been noted as factors contributing to high rates of both homelessness and emergency service utilization (Nelson et al., 2007; Pankratz et al., 2017). Research estimates the Canadian homeless population to be approximately 35,000 people (Gaetz et al., 2016), and findings indicate that those experiencing “chronic homelessness” are a subgroup characterized by high rates of mental illness and substance use (Pankratz et al., 2017). Some research has shown that increasing housing stability for consumers with serious and persistent mental illness can result in secondary gains that include increased sense of well-being, increased food security, and improved community integration (Canham et

al., 2017; Coldwell & Bender, 2007; Nelson et al., 2007; Pankratz et al., 2017). Research has shown ACT to be an effective model for maintaining treatment continuity with consumers during periods of homelessness, and although results are mixed (Bond & Drake, 2015), some research has shown ACT treatment can reduce homelessness and increase periods of housing stability (Burns & Santos, 1995; Chinman et al., 2017; Coldwell & Bender, 2007; Meisler et al., 1997).

The ACT model has an extensive history of being paired with other evidence-based interventions to increase treatment efficacy with special populations and to address specific issues. One such intervention is known as Housing First, a model that has shown effectiveness in reducing emergency room use, improving psychiatric symptomology, increasing adherence to psychotropic medications, reducing justice system involvement, and improving psychosocial outcomes for the same high-needs population often served through ACT teams (Canham et al., 2017; Padgett et al., 2006; Rezansoff et al., 2017; Salyers & Tsemberis, 2007). Housing First can be used as a stand-alone intervention, but for consumers with complex mental health needs it is often combined with added supports such as Intensive Case Management (ICM) or ACT (Canham et al., 2017; Nelson et al., 2007; Somers et al., 2017). Housing First is premised on a hypothesis that providing housing, and personal agency to make housing choices, can increase housing stability as well as produce secondary outcomes: reduced use of crisis response services, increased treatment retention, and improved health outcomes among recipients (Canham et al., 2017; Padgett et al., 2006; Rezansoff et al., 2017). Housing First is predicated on evidence that by meeting an individual's basic housing needs, other "higher-order" needs will eventually be raised to the forefront by consumers and then addressed by the clinical supports paired with them (Nelson et al., 2007). Housing First can be contrasted with a "treatment-first" or "housing-readiness" approach, where consumers with mental illness are treated and stabilized prior to being assessed for housing "readiness" by professionals who then match consumers to an appropriate resource (Padgett et al., 2006).

Although differing impacts have been associated with specific services paired with Housing First (such as ACT and ICM), some research shows that the provision of "permanent" housing produces the greatest effects in reducing homelessness, irrespective of the support model paired with it (McPherson et al., 2018; Nelson et al., 2007). Although the ACT model has been matched with Housing First with positive

results, the high rates of homelessness and housing instability among ACT consumers has also led to research examining the ACT model's independent impact on this domain (Coldwell & Bender, 2007; Nelson et al., 2007; Rosenheck & Dennis, 2001). Some research has shown that ACT treatment alone can increase housing stability for consumers (Bond et al., 2001; Coldwell & Bender, 2007; Kelly et al., 2017; Meisler et al., 1997), and ACT paired with supported housing services has produced positive housing results for consumers with concurrent substance use disorders, extensive periods of homelessness, and previous disengagement from supportive housing services (Tsemberis et al., 2004). However, findings showing positive housing outcomes appear less prominent compared with the ACT model's reduction of hospitalization rates and maintenance of treatment bonds in community settings (Bond & Drake, 2015). It has also been argued that ACT interventions tend to focus on meeting consumers' basic housing needs rather than on more robust recovery-related definitions of success such as securing "permanent" housing, which has been shown to promote long-term social reintegration for consumers (McPherson et al., 2018; Nelson et al., 2007).

Although homelessness and housing instability among ACT consumers have been recognized as important topics, they remain relatively underexplored in ACT-focused research. This is especially the case with regards to qualitative inquiry, where there is an overall paucity of research examining experiences related to homelessness, housing instability, and the housing-related interventions used by ACT service providers. My research seeks to shed light on this area by exploring the experiences of service providers and consumers from ACT teams with embedded police officers operating in a setting with limited housing resources.

5.2. Methods

A form of qualitative methods known as grounded theory ethnography informs the conduct of my research. These methods are well suited to this project because they combine the collection of robust data through interviews and focused observational fieldwork with ongoing analysis to generate knowledge about experiences, meanings, and perspectives from the standpoint of participants. Grounded theory ethnography combines focused ethnographic fieldwork with elements of grounded theory such as in-depth interviews, the constant comparative method of analysis, theoretical sampling, and the goals of reaching coding saturation and descriptive theory generation (Charmaz,

2006, 2009). Grounded theory ethnography evolved from “constructivist grounded theory” and embraces more flexibility and creativity than traditional grounded theory (Charmaz, 2006). Grounded theory ethnography is informed by social constructivism, which acknowledges that multiple discourses exist about any given phenomenon and that these are mediated by the social and cultural norms of those experiencing it (Chamaz, 2006; Creswell, 2018). A social constructivist lens accepts that alternative discourses necessarily exist about this same phenomenon (Creswell, 2018), and research is viewed as intertwining the researcher and participants within a meaning-making process such that they co-construct shared discourses about the phenomenon being studied (Charmaz, 2006; Taylor, 2018). Drawing on grounded theory ethnography provided me with a set of inductive methods that facilitated the exploration of emergent themes rather than the imposition of preconceived conceptions and theories on the phenomenon being studied (Charmaz, 2006).

Data for my research were gathered primarily through interviews and focused observational fieldwork. Forty-seven in-depth qualitative interviews were conducted with ACT service providers (N = 23) and consumers (N = 24). Recruitment of ACT service providers was undertaken through email invitations forwarded to potential participants through their health authority employer, as well as snowball sampling and peer-driven recruitment. Service provider interviews lasted between 40 and 90 minutes and were conducted at a variety of locations, including coffee shops, offices, and community centres.

Several methods were utilized to recruit ACT consumers and to address what I view as limitations of previous research. Most qualitative research involving ACT consumers has recruited almost exclusively through service providers working on these teams (see Cuddeback et al., 2011; Krupa et al., 2005; Milbourn et al., 2014; Thøgersen et al., 2010; Watts & Priebe, 2002), which has likely promoted a selection bias towards consumers considered “engaged” in services and psychiatrically “stable.” I undertook a unique recruitment method that was independent of treatment providers and chose not to exclude participants due to overt mental illness symptoms, except in cases where this impaired their ability to provide informed consent. In rare cases where informed consent could not be attained, consumers were invited to participate in an interview on another date.

Recruitment of ACT consumers in this study was primarily through three ongoing prospective cohort studies conducted through the British Columbia Centre on Substance Use (BCCSU): The Vancouver Injection Drug Users Study (VIDUS), the At-Risk Youth Study (ARYS), and the AIDS Care Cohort to Evaluate Exposure to Survival Services (ACCESS). Details of the methodology used in these prospective cohort studies have been described in depth by other researchers (see Strathdee et al., 1997; Wood et al., 2001). To briefly summarize, cohort participants have been recruited through self-referral, snowball sampling, and outreach. The VIDUS cohort is made up of HIV-negative adults who use drugs. The ACCESS cohort consists of HIV-positive adult drug users (including VIDUS cohort members who seroconverted to HIV following enrollment in that study). The ARYS cohort is made up of street-involved youth and was established to better understand factors influencing the health of this population. All three of these prospective cohort studies utilize interviewer-administered questionnaires, medical clinic visits, as well as in-depth qualitative interviews to collect data.

I added items to the questionnaires administered at regular intervals to these three cohorts to identify potential ACT consumers. Once individuals were flagged through these questionnaire items, further screening was conducted by trained research staff at two storefront BCCSU offices. Potential participants meeting eligibility requirements were provided with a brief verbal synopsis of the study and description of its conduct. Interested eligible participants were then booked into a designated appointment slot for an interview. Although I initially planned to interview consumers primarily at the storefront offices of the BCCSU, this proved to be ineffective as many potential participants were unable to attend these offices during specific appointment times. To adapt to the needs of participants, in-depth interviews were therefore also conducted at alternative mutually agreed upon locations, such as consumers' residences, coffee shops, community centres, and emergency shelters. Interviews with ACT consumers lasted between 20 and 80 minutes, and CAD 30 honoraria were offered as compensation for their time.

Over 90 hours of focused observational fieldwork and informal interviews were also conducted towards acquiring a more thorough contextualization of interview data and as a primary data source. Observational fieldwork was conducted in public spaces of The Block (a pseudonym for a marginalized neighbourhood in a large BC municipality), as well as in more private spaces (such as a participant's suite if I had

been invited). I used a verbal script to identify myself as a researcher during fieldwork. Consistent with grounded theory ethnography methods, my observational fieldwork was focused geographically and temporally to maximize potential opportunities to experience episodes of ACT service delivery. Field notes and voice memos were used to record this fieldwork, and these were used to triangulate results, inform analytical direction, and provide primary data. Observational fieldwork also became a mechanism of recruitment and facilitated theoretical sampling of ACT consumers who were not in the BCCSU cohorts.

All in-depth interviews were audio recorded and later transcribed and uploaded to NVivo 12 qualitative software to facilitate analysis. Constant comparative analysis techniques promoted the pursuing of emergent themes during the recruitment, interview, and fieldwork processes. After all interviews were completed and transcribed, a coding framework was developed through collaboration with two members of my PhD committee (Dr. Small and Dr. Jenkins). Sections of de-identified transcripts were also reviewed with two volunteer ACT consumers as a means of member checking and to verify the developing codebook. The coding framework was then applied to all transcripts, and larger themes that crossed between service provider and consumer interviews were explored in further detail. Social constructivism, which acknowledges multiple discourses about any given phenomenon, was used to make sense of congruencies and incongruencies in experiences related to similar phenomena. Axial coding was used to explore relationships between codes, and deviant case analysis examples were used to test theme strength and explore alternative meanings. Once dominant themes were identified and tested for analytic strength, transcripts were analyzed using selective coding to pull subthemes into a cohesive storyline. A process of draft writing was then used to organize these themes towards developing a descriptive theory of the overall phenomena.

5.3. Description of Participants

Although presenting the characteristics of individual participants (e.g., gender, profession, experience, diagnosis) along with quoted text would enrich contextual detail, I chose an alternative approach to enhance confidentiality. I assigned a numerical code to each participant and converted potentially identifying demographic details into aggregate form. Quotes identify participants through a numerical code followed by the

letters “C” for consumer participants and “SP” for service providers. Consistent with the social constructivist underpinnings of grounded theory ethnography, I present my findings using terms such as “many,” “most,” “some,” and “few” rather than assigning numerical values to a given theme or subtheme, such as “30% of participants.” My intention is to provide readers with the relative strength of a given theme while avoiding positivist assumptions related to certainty of findings based on numbers or percentages.

5.3.1. Service Providers

The age of service providers ranged from 31 to 63 (mean = 43). Fourteen of my service provider participants were male and nine were female. Participants had between one and seven years (mean = 3 years) of experience working on an ACT team (in any jurisdiction) and two to 35 years of total work experience in their profession or occupation (mean = 11 years). My service provider participants included physicians, nurses, social workers, occupational therapists, concurrent disorders counsellors, police officers, and peer support specialists.

5.3.2. Consumers

Seventeen consumers identified as male and seven as female. Their ages were between 25 and 62 (mean = 43 years). Thirteen participants self-identified as Caucasian, nine as Indigenous (respectfully inclusive of First Nations, Métis, and Inuit), and two identified as black. Nine participants were recruited from VIDUS, two from ACCESS, and five from ARYS. Eight individuals were interviewed who were not involved in the cohort research but were recruited through observational fieldwork and snowball sampling. At the time of their interview, 16 consumer participants resided in either privately or publicly owned single room occupancy hotels (SROs), three resided in emergency shelters, and three were unsheltered or living in absolute homelessness. One participant resided in “addiction housing” and another in a licensed group home care facility.

Sixteen participants reported their primary diagnosis to be schizophrenia, four reported schizoaffective disorder, one reported “psychosis,” two reported bipolar disorder, and one reported depression and anxiety. Consumer participants did not necessarily agree with their diagnosis. Fifteen participants reported at least one

hospitalization in the previous year (two were for primary care medical issues rather than psychiatric reasons), and the length of hospital admission ranged from one to 90 days. All participants reported histories of polysubstance use, and 22 reported current use. Most of my consumer participants reported being mandated to treatment by their ACT teams. Nineteen participants reported being involuntarily treated under the Extended Leave provisions (community treatment orders) of British Columbia's Mental Health Act legislation. An additional three participants reported that in the previous two years, they had won Review Panel hearings to remove themselves from Extended Leave.

5.4. Results

I present my findings under several themes: a city with no housing; transitional housing; trauma and the stigma of place; housing is a hook; and a broken housing system. My findings showed that consumers of these police-embedded ACT teams faced a housing-scarce environment in which structural barriers restricted available housing options and increased competition with others seeking these same options. My findings also emphasized how homelessness and housing instability could be barriers to ACT treatment delivery and impeded mental wellness and recovery potential for consumers.

5.4.1. A City with No Housing: “We have zero housing options.”

Both service providers and consumers experienced challenges with housing. In the words of one service provider: “we have zero housing options” (ACT 14SP). Six of my consumer participants (25%) resided in temporary emergency shelters or were street homeless (i.e., absolutely homeless) at the time of their interviews. All of these six consumers expressed a lack of hope that ACT service providers would successfully find them permanent housing and instead had turned to outside agencies for assistance. For example, one consumer participant noted: “I’m going to go to Aid Society¹¹ and try to get some housing help with them” (ACT 29C). This finding may seem insignificant on the surface but is notable within the context of ACT model fidelity, which promotes service

¹¹ Aid Society has been used as a pseudonym for the program referred to by this participant. In The Block there are a number of non-profit organizations that assist with housing. This participant is referring to one such service that provides outreach services in The Block and assists people with navigating housing, food security, and social service systems.

delivery through, or coordinated by, ACT service providers rather than it being brokered to outside agencies. When I explored the issue further through interview questions, I found that these consumers experienced shortcomings with ACT's multidisciplinary, shared caseload model, whereby no individual worker was seen as being responsible for their care. Consumers described having to "start from the beginning" at every contact with different ACT service providers and expressed frustration with a lack of continuity in moving forward with long-term goals such as securing permanent housing. Related to this, the majority of consumers also experienced frustration about what they viewed as ACT service providers' primary focus: monitoring either medication adherence or medication administration. The following data excerpt from a homeless consumer provides an example:

They just make sure I take my meds every day. I don't really deal with them all that much. All they do is really [is] check in every once in a while, tell me to take my meds. That's how it's been lately . . . just make sure I take my meds and they kind of help . . . try and help me with housing a little bit. They don't really talk to me enough to know anything about that. (ACT 29C)

The majority of consumers experienced that the domination of medication-related activities by ACT service providers was at the expense of issues that were important to them, such as securing permanent housing, achieving food security, and taking steps to find employment. It was common for consumer participants to share that their interactions with ACT service providers were experienced as "monitoring" rather than treatment, and some participants used the term "mental police" to describe a perceived monitoring and enforcement roll for ACT service providers. These experiences of monitoring appeared to be exacerbated by the involvement of embedded police officers and the law enforcement role they brought to these ACT teams.

Consistent with the perceptions of my consumer participants, I found that the majority of ACT service providers believed pharmacological interventions should be the primary focus of ACT treatment. However, my findings also showed that securing shelter for homeless clients was a nearly equal priority because homelessness was experienced as a major barrier to locating clients, a necessary precursor for providing consistent pharmacological treatment. The following service provider shared their frustration about trying to locate homeless consumers:

How difficult is it to do outreach on someone (when) you don't know where they live? You're trying to find them, all you have is you start doing some stakeouts. Maybe you go see the shelters, maybe start walking around underneath the bridges. If you know where they are. If you have time. And maybe you have a picture, maybe you never met them before, right? (ACT 13SP)

My findings showed that this experience of not knowing or not having met consumers was common for ACT service provider participants, especially when consumers were newly enrolled in ACT. The shared caseload model of ACT was experienced as reducing the frequency of contacts between any given service provider and consumer, making it difficult for service providers to recognize or identify consumers living in emergency shelters or experiencing homelessness. Another service provider expressed frustration with their inability to form therapeutic bonds with consumers and saw this as directly related to substandard housing and homelessness:

People aren't securely housed. You can't talk about treatment when people live in an SRO, or they're street homeless . . . my job is keeping people alive. That's it. . . . But you talk about . . . [laughs] trying to actually treat people, and trying to improve people's quality of life, or what would be meaningful for a client in terms of "what I want my life to look like," we're not anywhere near that. (ACT 2SP)

Some ACT consumers who had experienced periods of homelessness while receiving ACT services described difficulty in maintaining contact with their ACT teams during those times. ACT consumers described how the multidisciplinary treatment model created confusion as to which service providers should be contacted on any given day. Some consumers also noted that because their ACT service providers utilized outreach as their primary form of service delivery, it was difficult to physically locate them. This was contrasted with office-based teams, whereby a consumer had a designated location (office) where a service provider was expected to be during operating hours. Consumers also critiqued the location of the ACT offices, which were some distance away from The Block neighbourhood where large numbers of ACT consumers resided. Consumers reported barriers to communication with ACT service providers associated with having to forward and receive messages through third parties, such as community centre or building staff, because of economic marginalization that precluded them from owning their own phones. One consumer provided the following example:

It's hard to get a hold of them every day, especially [because] I'm homeless, right. . . . I just wait for them to leave a message and then I try calling them and I try to get a hold of them, but they all have different phone numbers and they all are doing something. I don't know. They're hard to get a hold of. They're usually busy and stuff. (ACT 29C)

I found that homelessness posed such a barrier for service providers to connect with consumers that it influenced clinical decision making. For example, homelessness could precipitate a decision to switch a consumer to a long-acting injectable medication instead of a daily oral option. From the perspective of service providers, these decisions were sometimes made because of a consumer's housing situation and barriers this created to medication administration and monitoring. In other words, these decisions were made irrespective of the response a consumer had to a given medication or their preference. In particular, the medication Clozapine,¹² which was perceived by service provider participants as a gold-standard oral medication for treatment-resistant (refractory) psychotic symptoms, was often discontinued when housing environments created barriers to monitoring daily medication adherence. One service provider shared such an experience related to an ACT consumer who had made gains while in hospital on this oral medication, which was later discontinued due to concerns related to the discharge housing environment:

The physician was like "well, maybe he shouldn't be on oral medications because it is not realistic to administer them in the community" . . . which I get on one hand, but on the other hand, he was the best that he's ever been in tertiary¹³ on that med profile. (ACT 25SP)

¹² Service providers shared that although this medication can be effective, it also has a number of health risks that necessitate medical monitoring, including regular blood work, as the dose is slowly titrated (increased). It is also a medication that requires regular adherence, and if a number of doses are missed, it must be restarted at a low dose and slowly increased again. Participants shared that this titration process usually necessitated a hospitalization.

¹³ Deinstitutionalization in the province of British Columbia occurred over an extended period of time, and the closure of Riverview Hospital did not occur until 2012. The downsizing and closure of Riverview corresponded temporally to the emergence of a "tertiary" hospital system of care providing long-term, but time-limited, inpatient care focused on diagnostic clarification, medication optimization, and intensive psychosocial rehabilitation. Admission to tertiary hospitals usually requires that a consumer has exhausted both primary and secondary resources. Primary resources include non-specialized care such as that provided by a family doctor. Secondary

This finding was important when considered within the context that ACT services were reserved for consumers with difficult to treat mental health conditions that often resulted in complex pharmacological interventions. I found that although ACT consumers could make significant gains through tertiary hospital admissions, these were often lost because of restricted and inferior housing options upon discharge.

Many service providers also experienced homelessness and inferior housing as destabilizing forces negatively impacting psychiatric symptoms and potentially precipitating cycles of crisis for consumers. However, my findings showed that responses to increased symptomology were usually pharmacological and directed at symptoms rather than addressing what participants experienced as root causes of psychiatric decompensation, such as inadequate housing, poverty, and social exclusion. A large number of both service provider and consumer participants also perceived that crisis response interventions in any form usually became the primary driver of ACT service delivery, which necessarily displaced long-term goals, such as improving a consumer's housing situation. The following excerpt provides context:

Managing crisis . . . It seems to me that all of those [larger] goals are always put on the back burner, the reunification with family, or volunteering, or vocational stuff, I don't know what else, but there is just very little done around those goals. (ACT 18SP)

Both service providers and consumers shared stories suggesting that once a consumer was "housed," even if housed in a substandard environment or temporary shelter, the "crisis response" focus related to housing abated and the work of finding improved housing became low priority. The following data excerpt provides a perspective on this crisis response focus and how it created barriers to working on long-term goals:

Because we're just fighting the crisis and then after that what [do] we do? We don't know what to do. You know, when you're a firefighter, all you do is fight [fires]. You get out of the place and someone else will do the construction and everything. So, our ACT has become more of a firefighter. (ACT 19SP)

resources include specialized resources such as psychiatry and specialized community treatment services.

This participant went on to describe how relying on “someone else” often translated to service providers brokering out to external service providers for these long-term goals, or in some cases, leaving it to ACT consumers to access and navigate external services themselves.

For many ACT consumer participants, narratives regarding a lack of choice in where they could live were common, with a dominant perception being that their treating ACT team had control over housing options available to them. A dialectic emerged in my findings whereby consumer participants with housing were thankful for the shelter they had but at the same time expressed discontent that they lacked agency in choosing housing options, and they perceived ACT service providers as engaging in paternalistic practices. The following quote from an ACT consumer shows their frustration with lacking autonomy in housing decisions but also reveals their goal to not just rent but ultimately own a home:

Usually they'll put you in a crappy hole. . . . ACT team workers push you around until you will just about take just anything. But I want my own house. I can pay a mortgage. And I will have a place to live if [redacted name] wants to visit. I don't want to live in a goddamn glorified hotel room. (ACT 43C)

In the above account, the “glorified hotel room” that the participant referred to was a supported SRO in The Block, characterized by participants as harm-reduction focused (for example, by having safe consumption rooms and easy access to syringes). Participants described such harm-reduction housing sites as having prolific on-site open substance use and easy access to substances, and being frequented by predatory drug dealers. My observational fieldwork indicated that SROs such as this typically provided only a single room with no kitchen facilities, and a bathroom shared by the entire floor of occupants. Also important in the previous excerpt is that the participant noted wanting a home where their friend could visit. It was common for consumer participants to share perceptions that supported housing environments often came with constricting rules around guests and visitors.

Interviews with ACT service providers facilitated a deeper understanding of instances that consumers experienced as paternalistic housing practices. My results suggested that the supported housing system was largely external to ACT service

providers and provided them with limited or no input in decision making, despite consumer perceptions to the contrary. Therefore, consumer frustrations with bureaucratic decision making, lack of transparency, and long wait times were often focused on ACT service providers despite them having little or no ability to impact these. My analysis suggested that one of the reasons for this misconception stemmed from ACT service providers assisting consumers with applications for housing, which was interpreted as synonymous with having decision-making power. I also found that ACT service providers sometimes promoted the potential that they could assist consumers with housing as a tool for building engagement with them. This sub-theme will be explored in more detail later in this chapter.

I found that the few housing sites ACT service providers could directly access for consumers were primarily limited to market housing options such as privately operated SROs. Within the context of limited resources, many service provider participants planned strategically to maximize these available housing options and maintain relationships with landlords. One service provider equated the housing system to a “chess board,” where strategy and patience were necessary in order to optimize limited housing resources. The following quote from a service provider shows their thought process related to using such a resource:

I developed a relationship with one of the buildings, which is a very quiet building, and he [the landlord] has suites available. But I am hesitant to put him [the ACT consumer] in there. I want it to be appropriate. . . . The flip side of that is when there’s just SROs available, I don’t know how anyone is supposed to get any sense, any experience, with recovery in that environment because it’s so stressful living in those places. I can’t even imagine. (ACT 10SP)

The service provider later described that this desirable suite remained vacant in order to maintain a relationship with the landlord. The consumer he spoke of was later housed in a decrepit SRO despite the service provider acknowledging that the environment would likely create serious barriers to mental wellness and treatment delivery.

Service providers also shared that the embedded police officers on these ACT teams could facilitate or create barriers to the establishment of positive relationships with landlords. Several service providers shared that the police-embedded ACT model

created opportunities to house consumers with histories of problematic behaviours because some landlords perceived that there would be an enhanced police response if they needed it. On the other hand, some service providers noted that landlords could be hesitant to house an ACT consumer because the presence of embedded officers within the model was equated with dangerousness and the need for protection from those consumers. I also found that some landlords did not want enhanced police presence in their buildings due to privacy concerns for themselves and their residents.

Both service providers and consumers emphasized how the housing shortage in their municipality constricted options and increased competition for limited resources. Both groups of participants perceived the lack of options to be related to poverty and structural constraints. Specifically noted was the CAD 375 per month shelter portion for rent available to consumers through disability-based income assistance (welfare) in BC. Both service providers and consumers viewed this amount to be woefully inadequate in the context of an overall lack of affordable housing and rapidly escalating rents.

Both consumers and service providers expressed concern that the majority of housing options, including supported housing, available to ACT consumers were located in harm-reduction focused buildings. Several consumers experienced that such harm-reduction environments made it difficult to reduce their level of use, or remain abstinent, if that was their intention. This was often attributed to the prolific availability of substances and the normality of open substance use in these settings. One consumer who had recently attended a residential substance use treatment centre described how being discharged to a harm-reduction environment triggered him to relapse into substance use, emphasizing the importance of physical distance from visible drug use and opportunistic dealers: “But I need to be totally away from people I know who sell drugs because I’ll go to [buy], as soon as I get money” (ACT 46C).

A service provider shared a similar perspective on the barriers to consumers maintaining abstinence in such harm-reduction housing environments:

The problem is if someone wants to live abstinent . . . it’s like taking a mouse and putting him in a cheese shop and saying “please don’t eat the cheese. But if you do eat the cheese here’s a napkin and a fork and knife so you can cut the cheese

off nicely and eat the cheese healthy [sic]. But, please don't use the cheese."
(ACT 14SP)

I identified a paradox experienced by ACT service providers related to a perceived over-representation of harm-reduction focus in housing options that were attainable for ACT consumers. Although harm-reduction was broadly experienced by ACT service providers as positive due to public health impacts such as reduced disease transmission and fewer overdoses, most service providers nonetheless struggled with what they perceived as an "inevitability of use" for consumers living in these environments.

A majority of both service providers and consumers expressed that substance use, and in particular stimulant use (e.g., crystal methamphetamine), had the potential to profoundly impact mental wellness by exacerbating psychiatric symptoms. Some consumers even perceived that their enrollment in ACT, and subsequent mandatory pharmacological treatment under BC's Mental Health Act, was directly related to their substance use. In other words, these consumers perceived that it was substance use, rather than mental illness, that justified their mandated treatment through the ACT model. Further, these consumers believed that their mandated treatment was unfair because of the inevitability of using substances in the housing environments available to them. They viewed such mandated treatment as a mechanism of controlling their lives, policing their substance use, and providing employment opportunities for more affluent citizens as ACT service providers. These perceptions appeared to be exacerbated by the involvement of embedded police officers in this ACT model because of the enforcement role personified by these officers.

ACT service providers described a blunted "spray and pray" approach whereby antipsychotic medication was sometimes administered as a prophylaxis with the hope that it would address both underlying symptoms of mental illness and symptoms that were perceived to be substance induced. Ironically, I also heard stories of how participants believed that the administration of antipsychotic medications increased the levels and chronicity of substance use for some ACT consumers. A service provider gave the following example:

I think it [antipsychotic medication] has a sedating effect that . . . is forced on them. That's legitimate, and that they don't enjoy that, and I think it probably sort of blunts their thoughts a bit. . . . They [consumers] . . . very often seem to gravitate towards stimulants to counteract that. So, it leads me to think okay, well this is doing something to sedate them that they . . . are forced and they don't like, which is fair enough. I wouldn't like it either. So, they're counteracting that with this increased stimulant use. (ACT 1SP)

Several consumer participants who used stimulants shared beliefs that their “high” from substance use was negatively impacted by medications, which resulted in perceptions that they needed to use more of that substance, or to use it more frequently, to achieve the desired effect. Some consumers claimed to negotiate with ACT service providers to delay the administration of their injectable medication if it coincided with the monthly payment (cheque day) from income assistance (welfare), to allow them to experience a high prior to receiving the medication. Some service providers shared similar experiences where changing the date of medication administration was used as a bargaining tool to increase treatment buy-in from consumers.

In summary, both ACT service providers and consumers experienced limited housing options. This constricted market, coupled with enhanced competition for remaining resources, reduced the potential housing options for ACT consumers. Of the options available, harm-reduction housing predominated but was experienced as enhancing the risk of substance use, which was potentially destabilizing for mental health symptoms. Although service providers experienced homelessness as a barrier to providing treatment, especially pharmacological interventions, they sometimes passed over potential housing options for “problematic” consumers in order to maintain positive relationships with landlords. Consumers identified the team-based nature of ACT service delivery to be the biggest barrier to working on long-term treatment goals such as finding permanent housing.

5.4.2. Transitional Housing: “It’s ridiculous. ‘Here’s two years of housing, you’re doing great; out you go!’”

While my findings showed that a scarcity of housing options for ACT consumers was experienced by both groupings of participants as having widespread and profound

impacts, I also found that within this constricted market, a “transitional” housing model dominated and was often paired with the publicly subsidized “supported” housing continuum.

My participants shared that within this setting, a provincial crown corporation (BC Housing) managed and administered all publicly subsidized housing options. Two broad streams (independent and supported housing) were used to classify and separate different demographics of applicants. Proof of low income, risk of homelessness, and a mental health diagnosis and/or substance use were required to access supported BC Housing, and my findings showed that ACT consumer participants often utilized this stream because of their high level of system-identified needs. I found that the level of ‘support’ in this housing continuum ranged from part-time peer staff to on-site clinics staffed by medical professionals. Participants experienced great variation in how ‘support’ was operationalized between buildings purporting to offer similar levels of assistance. My findings emphasized that both consumers and service providers found the supported housing system to be difficult to navigate or even understand.

My findings also showed that many of these supported housing options were classified as “transitional,” with an explicit end date to tenancy. I found that this time duration cap (often two years) required tenants to move to another building, even if they continued to require the same level of support. In other words, consumers were forced to transition to another site due to system pressure rather than their needs. Both groupings of participants experienced the time duration cap on transitional housing as an arbitrary limit imposed to create artificial “flow,” with no bearing on the time required for ACT consumers to reach “stability” or find permanent housing at another location. One service provider explained: “Yeah, it’s ridiculous. ‘Here’s two years of housing, you’re doing great; out you go!’” (ACT 5SP). Both ACT service providers and consumers experienced a lack of power in their relationships with housing providers and perceived this transitional system as inflexible and potentially undermining to the mental well-being of ACT consumers. Service providers shared experiences of their input regarding the potentially destabilizing impacts of transitional housing often being ignored, despite the system costs associated with psychiatric decompensation, and the likelihood of trauma for consumers associated with this.

My participants also shared that although BC Housing was the administrator of these supported housing buildings, they were operated through contracts with other organizations that staffed them and took care of day-to-day operations. I found that ACT consumers who transitioned from one building to another in the supported housing continuum often experienced differing philosophical orientations and “ways of doing things” between these housing providers, which amplified the disruptiveness of physically moving from one building to another. I noted exceptions to this theme in a subgroup of service providers and consumers associated with one of the police-embedded ACT teams staffed by a non-profit housing provider under contract by the local health authority. I refer to this team as the non-profit ACT (NP-ACT) team in this dissertation.¹⁴ The NP-ACT team was a legacy of the At Home/Chez Soi study (hereafter the At Home study) and was still practicing from a Housing First orientation. The non-profit organization that staffed this ACT team also operated several supported housing buildings in The Block neighbourhood. I found a minority of experiences specific to service providers and consumers from the NP-ACT team suggesting that this agency’s role in operating supported housing buildings facilitated more housing opportunities for their consumers than other police-embedded ACT teams staffed by health authority staff. My findings showed that NP-ACT consumers received more choice and continuity of care from housing providers, in part because of the network of housing options operated by this non-profit and the consistent philosophy of staff in these buildings.

Consumers and service providers shared stories that showed how the label “transitional” can remove building operators from the constraints and legal safeguards of the Residential Tenancy Act (RTA) and can permit practices such as building staff entering suites without notice. Service providers and consumers both shared stories of hasty evictions, whereby little notice was given and no recourse was available to challenge the eviction process because of exemptions to the safeguards provided by the RTA. I found that for consumers, transitional housing was usually experienced as a source of instability, which could contribute to trauma related to frequent moves as well as perceptions of lacking control in their lives. Transitional housing was also associated with social disconnection by several consumer participants. Some ACT consumers who knew that their tenancy was limited to a given period of time shared that they purposely

¹⁴ The pseudonym NP-ACT team has been used throughout the dissertation to mask the location of this research and enhance confidentiality for participants.

avoided forming social connections within the building and larger neighbourhood in order to reduce losses when the inevitable move came. Every consumer participant residing in transitional housing stated a preference for permanency over their current situation, even if they thought that the permanent housing would be substandard in comparison to their current living situation. In other words, I found that permanency was viewed by consumers as more important than other features, such as location, cleanliness, and on-site building services. The following ACT consumer was asked what one thing they would like in their future, and their response emphasized the difficulty they experienced finding permanent housing: “Yeah, I will tell you. Permanent housing. I’ve waited five or six years for permanent housing” (ACT 23C).

The previous data excerpt is important in part because this consumer had been receiving services from ACT for several years. They perceived that during this time, although their primary treatment goal was to secure permanent housing, their ACT service providers were largely inept at assisting with this goal. Further, this participant perceived this failure to assist as tantamount to service providers not listening to them and shared that this damaged trust in their therapeutic relationship.

For most service providers, concerns were not restricted to a lack of housing but extended also to a lack of what they perceived as “appropriate housing.” I noted two variations of this theme within service provider interviews, which I have categorized as Housing First or “housing readiness” orientation. The majority of ACT service providers perceived a need for more “supported” housing options, with on-site staff and supports (such as monitoring medication adherence and conducting medication administration), in which to “put” consumers once assessed as “ready.” A minority practiced from a Housing First perspective, wanting consumers to have increased access to a range of housing options, including market housing, from which they could pick their most desired location. My findings suggest that the Housing First and “housing readiness” groupings were usually mutually exclusive, and I found that participants endorsing one of these orientations often found fault with the other. The following account from a service provider illustrates the different philosophical orientations regarding housing:

It doesn’t feel much different for me than when like At Home/Chez Soi ended because [this setting] was the only site that didn’t scale up their housing, whereas cities across the country did. . . . [My employer] pooh-poohs Housing

First. You know we treat [the NP-ACT team] with kind of weird eyes like you know “oh they have a different philosophy” but no one . . . ever says “well maybe they have the right philosophy. Let’s learn from them!” . . . It’s a tool that we haven’t scaled up for whatever reason ’cause people are afraid to get in trouble or there’s not the political support for that. But this is not a new issue. . . . We ended it [the At Home study] in 2013 and we still have the same problem. (ACT 22SP)

The preceding data excerpt is important not only because it identifies the different philosophical orientations of Housing First and “housing readiness” but also because it illuminates a perceived resistance to embracing Housing First methods, despite evidence of their proven efficacy in Canada. This should be considered in relation to my finding that most consumers expressed a desire for enhanced choice in their housing options. My analysis pointed to scarcity of housing as the primary driver behind service providers dismissing Housing First as an option. Even participants who expressed a Housing First orientation described profound barriers to implementing its principles in practice. Scarce housing options, increased competition and rental rates, and discrimination against ACT consumers were central in perceptions of barriers to implementing Housing First for service providers who embraced its philosophy.

In summation, my findings showed that in addition to a constricted housing market, a time-limited “transitional” housing model predominated the options available for ACT consumers. My findings suggested that although this transitional model facilitated “flow” within the housing system, it was potentially destabilizing for ACT consumers. My results also called attention to competing tensions between Housing First and “housing readiness” orientations amongst service providers and how this contrasted with the experiences of consumers, who almost universally desired housing choice and housing permanency. My analysis supported that housing scarcity, high rental rates, and low affordability for ACT consumers surviving on income assistance created barriers to embracing the potential of Housing First in this setting.

5.4.3. Trauma and the Stigma of Place: “The place is a dive. It is horrific. Double murder stabbings there. Horrible conditions.”

ACT service providers and consumers alike spoke of “dangerousness,” “lack of safety,” and “trauma” associated with housing instability, substandard housing, and homelessness. My findings also called attention to a dominant discourse embraced by most service providers that totalized The Block neighbourhood as a dangerous space. Some service providers also transferred perceptions of dangerousness related to this neighbourhood upon the consumers they were treating. In other words, residency in The Block was necessarily equated with enhanced “dangerousness,” irrespective of a consumer’s individual attributes.

I found that although ACT service providers used different terms to describe housing instability, words such as “fragile,” “temporary,” and “transitional” were common. ACT service provider narratives often focused on how dangerousness, lack of safety, and trauma created barriers to service provision and/or treatment engagement. ACT consumers, on the other hand, usually spoke in terms of personal impacts that substandard housing and homelessness had on their lives and well-being. Although my sample of service providers included seasoned clinicians (mean = 11 years of clinical practice), the majority had not worked in The Block prior to employment with ACT. In fact, for a number of my service provider participants, ACT was their first community-based treatment experience, with their previous work having been in hospital settings. Further, most shared that their experiences working with issues such as trauma, poverty, social exclusion, and homelessness had been limited prior to working with ACT.

Several ACT service providers recalled how their work with ACT provided a training ground through which to learn about, make sense of, and respond effectively to the prolific trauma histories typically experienced by ACT consumers. While trauma was experienced as adding to the complexity of mental illness, my findings showed that the impacts of trauma were profound, even when psychiatric symptoms were in full remission. The following data excerpt provides an example:

We found a nice home for this one client and we went in there and got them a brand-new bed. . . . One of the first few visits we went in there, the bed was perfect, like no one had slept in it. And we’re like “what is going on?” . . . It was because when he was young his dad used to abuse him, sexually abuse him,

and abused his mother, and the only place he found comfort and safety was in his closet. This guy is 30 years old now and he's still sleeping in the closet. That is trauma. Regardless of whatever addiction he had or whatever mental illness he has, schizophrenia or whatever, that is trauma. We try to fit these people in these little neat boxes, "hey you should sleep on a bed" At that point was like, I get trauma now. I get what's going on here. (ACT 9SP)

This excerpt also touches on an important finding: that barriers to accessing or maintaining housing could arise from symptoms and behaviours that were responses to previous trauma. Although the previous participant spoke to behaviour (not sleeping in bed) that would have no impact on others, I also found examples of consumers whose reactions to trauma created barriers to acquiring or maintaining housing. For example, my data had examples of consumers who would wake up screaming from nightmares, some who were unable to enter confined spaces such as elevators or narrow stairways, and some with enhanced startle responses and reactive behaviours if touched by others such as staff or co-residents. My findings showed that such responses and behaviours could be interpreted by housing providers as signs of psychiatric instability and potential dangerousness. They were also experienced as constricting the available housing options for these consumers.

Almost all of my consumer participants shared that they had experienced periods of homelessness, and they provided examples of hazards, social marginalization, and compounded traumas directly related to living on the streets. Several reported that their experiences of homelessness had begun before they were teens. ACT consumers often linked periods of homelessness with episodes of psychiatric instability, and significant life events such as periods of forced hospitalization, loss of employment, dislocation from family and friends, the initiation of substance use, and major changes in substance use ingestion methods (e.g., from smoking to injecting). ACT service providers perceived periods of homelessness for ACT consumers as historical markers or defining points in their life trajectories, contributing to the functional impairment and complexities that eventually resulted in ACT enrollment. Some service providers also saw these as potential points of intervention in an ACT consumer's past that may have been opportunities for intervention to prevent the development of functional impairment. A service provider perspective gives context:

If I could make one difference in the mental health system, I would double, quadruple the amount of money going into schools, and mental health support going into schools. And there would be a social worker for every grade . . . for every fucking classroom! I would be intervening 10, 15, 20 years before ACT is ever even discussed in this person's life. That's where the money needs to go, in early, early intervention and getting that addressed. (ACT 1SP)

I asked every participant what they would do to improve ACT and the lives of the consumers it served, and I expected to elicit responses providing insight into ways to improve aspects of ACT service delivery. Almost all of my service provider participants identified early intervention strategies, such as in the previous example, that could have prevented the trauma and functional impairment experienced by ACT consumers and potentially changed trajectories away from ACT. This finding reinforced that functional impairment was not perceived as an inevitability of mental illness but rather as a telling marker of systemic failures to support people who developed mental illness in this setting. Conversely, most consumers responded to this question with an emphasis on increasing personal autonomy and agency in their treatment, and the view that ACT treatment priorities should be broadened beyond medication-related goals.

ACT consumers and service providers both described squalor and chaotic conditions in some SROs and shelters, contributing to perceptions of dangerousness. Observational fieldwork provided me with contextual details to better understand these environments. When I was conducting observational fieldwork, it was common to see rodents, bedbugs, and cockroaches as well as the sorts of chaotic living situations described by my service provider participants as negatively impacting the mental health and well-being of ACT consumers. While I carried out observational fieldwork and informal interviews in SROs, several consumers shared that they locked and barricaded their doors with heavy items, stating that this provided them with a sense of security. Informal interviews with consumers and service providers revealed that it was not uncommon for consumers to have defensive items (bats, golf clubs, and hammers) nearby that could be used if an intruder attempted to enter their suite. Field notes documented one encounter in which an ACT consumer disclosed that they slept in their shoes every night due to concerns about vulnerability and the potential need to exit the building quickly if danger arose. Field notes from an interview conducted at an emergency shelter also provided data on the normality of experiencing violence in these

environments. Field notes documented my concerns after a fight broke out in the common area outside of the room where I was conducting an interview. I noted that the participant only briefly paused before calmly continuing with the interview while the fight continued outside, which suggested to me that such violence was not uncommon.

Some service providers used negative and stigmatizing terms such as “ghetto” to describe The Block, where most ACT consumers resided. Most ACT service providers spoke of The Block as a feature, or attribute, in the lives of ACT consumers that necessarily added complexity to them and made them more difficult to treat. Some service providers used language that vilified The Block as dangerous space, and shared that they would only enter these areas with a second worker or the embedded ACT police officer accompanying them. Service providers often shared narratives of violence and crime associated with The Block. However, I found it notable that most of these concerns were associated with stories that they had heard from others, not personal experiences. The following data excerpt illustrates a second-hand narrative of potential violence within an SRO:

Yeah, like for a room with like rats and bed bugs and scary things happening in your hallway right outside your door and then like places like the [name of private SRO] where I didn't, I am surprised I didn't know this sooner, but it's actually really, really common and regular for your door to get kicked in when you're sleeping and have all your stuff robbed and get assaulted. (ACT 10SP)

While this excerpt pertains to the safety of residents inside of this building, it was common for service providers to extrapolate such threats as pertaining to their own safety. A narrative equating some SROs with potential extreme violence was dominant amongst my service provider participants. Another excerpt provides a similar example:

The place [SRO in The Block] is a dive. It is horrific. Double murder stabbings there. Horrible conditions. Now it is privately owned and they're charging \$550 a month for a place that doesn't have working bathrooms. . . . No safety, and the staff that work there are just as scary. They had a guy squatting in the hallway above the stairs throwing knives at the wall. (ACT 14SP)

This excerpt was also important because of the acknowledgment that not only was the setting perceived as dangerous, but also the monthly rent exceeded the CAD

375 shelter portion available to most consumers who survived on income assistance. It further underscored that these accommodations often lacked basic amenities such as working bathrooms. The following service provider spoke to the same issue and provided a broader perspective, emphasizing that substandard living conditions created barriers to addressing complex needs among consumers or even to forming a therapeutic relationship:

They are barriers to providing treatment. You turn up to someone's place, most people live in really substandard, dangerous housing. I don't go into people's rooms if I can help it. So, you're going to have a conversation in the hallway, which is not conducive to trying to build a relationship with people. So, you have a five-minute conversation. "Are you safe? When did you eat last? Do you need to get to your probation?" I mean, it's that level of intervention that we're doing. It's completely unlike what it looks like on paper when you talk about creating a therapeutic alliance and actually working on client goals. (ACT 2SP)

Several ACT consumers were conscious that their service providers took safety precautions such as travelling in pairs or ensuring the presence of the embedded ACT police officers when conducting outreach to their residences. Some consumers noted with irony that after their ACT service providers helped to find them housing in an SRO, these same service providers refused to visit that building except when accompanied by an armed police officer: "They brought police to my door. . . . They said just because it's safer for them . . . because of the people in the building and stuff" (ACT 29C).

Some ACT consumers perceived that this police presence might label them as a "criminal," while others expressed concerns that neighbours might think they were a "rat" (police informant). My findings showed that service providers often viewed and judged the living conditions of ACT consumers through the lens of their own experiences and privilege. I found that although these experiences sometimes accentuated narratives of dangerousness associated with ACT consumer's living environments, they also humanized and normalized some of the experiences and behaviours of ACT consumers living in "chaotic" environments. The following data excerpt illustrates how a service provider related their own home environment—and its relation to well-being—to the experiences of ACT consumers:

But it's not just mentally ill. I go home at night and sometimes my house is messy and I get anxiety. . . . I think I'm a pretty high-functioning individual and I still get anxiety when I'm in a chaotic environment and there are toys everywhere. I just want to sit down and relax and see a clean house and not have to see little cockroaches and rats running around. And I'm a high-functioning individual and I still get lots of anxiety about that. Maybe because I'm OCD, I don't know. But then we expect people who are mentally ill, drug addicted, to live in these chaotic environments and then be okay when we come knocking once a day to give them injections. And they're supposed to be pleasant to us? . . . it doesn't work that way. Because when I'm answering the door and I'm in that mood and some telemarketer [sic] is on the other side, I'm losing it on that person! So, I think it's a really key part of people's wellness. (ACT 9SP)

This excerpt also speaks to an important finding related to resistance from consumers towards ACT treatment. My findings showed that such resistance was sometimes interpreted from behaviours influenced by a consumer's trauma history or their current living situations, rather than ACT treatment itself. For example, a chaotic living environment could create irritability or reactive behaviours in a consumer that were interpreted by service providers as treatment resistance.

To summarize, my findings showed that homelessness and housing instability could be sources of trauma for ACT consumers and could reduce mental wellness. I also found that ACT consumers often had previous trauma histories that impacted their ability to acquire and maintain housing, and that these trauma histories could be exacerbated by poor housing conditions. I have presented results that service providers identified early intervention as a key to preventing functional deficits experienced by ACT consumers. My findings also called attention to a dominant discourse equating residency in The Block with danger and showed that this discourse shaped ACT service delivery. My results indicated that this stigma led to treatment decisions such as having officers accompany service providers on interactions with consumers, visiting in pairs, and refusing to enter private spaces with consumers during treatment encounters.

5.4.4. Housing is a “Hook”: “Like the carrot on the stick sort of thing”

My findings showed that in an environment of limited housing supply and enhanced demand, the potential to offer consumers housing could be a tool of engagement. ACT clinicians spoke extensively about difficulties they encountered trying to build therapeutic relationships with consumers. My results showed that such barriers were often associated with the extensive use of Extended Leave (i.e., community treatment orders), consumer experiences of trauma related to previous treatment, histories of negative police contact, and a lack of agency in relation to ACT enrollment. Service providers shared that these factors combined to put them at a considerable disadvantage when trying to engage and form relationships with ACT consumers. The potential to have a resource that could increase engagement with consumers (such as housing) was seen as overwhelmingly positive but usually out of reach.

Although service provider participants came from different professions and had diverse training, they almost universally described the benefits of forging a trusting relationship with consumers as a step towards having them “buy” into treatment. My findings showed that ACT service providers recognized that consumers valued housing, so they attempted to capitalize on this fact to create value in ACT treatment. In the words of one service provider, housing could be “like the carrot on the stick sort of thing” (ACT 13SP). However, my findings suggested that the “carrot” of housing was often limited to a process towards obtaining housing, but not housing itself. My results showed that service providers were cognizant that without direct access to housing, helping consumers to navigate the process of acquiring housing was often the best they could do to enhance treatment buy-in and begin building a therapeutic relationship. The following data excerpt provides an example:

You’re looking for the piece, the buy-in, that they might identify as you continue your engagement and increase your rapport with them, and you find out what that buy-in is, whether it is . . . I remember we always said “what is the hook?” Everybody has got that thing that they want to work with you on that they want, no matter what it is. (ACT 16SP)

Although most service provider narratives showed that they attempted to harness housing as an engagement tool, they did so with the knowledge that they had little power

to reach the goals their clients ultimately wanted. The following service provider explained:

Often that thing is housing, which is good because they're telling me that they want something. It's bad because housing is fucking impossible to find! They've asked me for the one thing that I am like "yeah! I'd love to help you with housing! It's super hard, but I will still try." (ACT 1SP)

My findings showed that offering assistance with the process of finding housing could increase initial engagement with consumers and create treatment buy-in. However, if housing were not eventually secured, or the option found was seen as inadequate by the consumer, this could result in lasting damage to therapeutic rapport.

Some service providers referred to rent subsidies known as "ACT Living" when speaking about housing-related issues and challenges. ACT Living referred to a limited number of rent subsidies available to a small number of ACT consumers. These subsidies, when combined with the CAD 375 shelter portion of income assistance, were intended to help consumers be able to access market housing (such as an apartment). Only one of my consumer participants had ever accessed such a subsidy during their treatment. For that consumer, the ACT Living subsidy was experienced in negative terms and associated with increased surveillance and a perceived loss of privacy. This consumer participant reported that the subsidy created a "landlord-tenant" type relationship with ACT service providers, and that they felt coerced into providing a key and unfettered access to their suite. This consumer perceived that service providers, including the embedded police officers, accessed their residence without notice or immediate permission, and they expressed concern about and opposition to these practices. I noted that some of the privacy concerns described by this consumer were odd in nature and may have been influenced by delusional beliefs. However, service provider interviews corroborated that ACT Living usually included a requirement that service providers have a key, and it was not uncommon for them to enter a suite to conduct "safety checks"¹⁵ if no one answered the door.

¹⁵ My findings showed that "safety checks" were a common practice in many supported housing environments. The term describes access to a residence for the purpose of determining that the occupant is "safe." My findings suggested that sometimes these checks were conducted to determine whether a resident was "missing" if they had not been seen by staff for some time. In

Service providers offered robust descriptions of experiences related to these ACT Living subsidies but often referred to them in the past tense. I found that competition for these subsidies had become more intense as the number of ACT teams in this setting increased while the number of rent subsidies remained largely unchanged. Service providers also shared that ACT Living subsidy amounts were not indexed to increase as rental rates escalated and therefore fell short of inflated contemporary market rental rates. Service providers shared creative solutions such as combining multiple subsidies together for a single consumer, but given that the overall number of subsidies was fixed, this reduced how many consumers could access ACT Living. Service providers also shared that ACT Living subsidies were tied to the program rather than to a consumer, which was experienced as a barrier to graduating to a less-intensive form of service delivery, as it necessitated revocation of the subsidy and potential eviction due to an inability to pay rent.

To summarize, my findings showed that in the context of limited housing options, service providers used consumers' desire for this resource as a "hook" to enhance buy-in to overall ACT treatment. However, I also found that ACT service providers had little power to provide housing and could only use the relationship capital associated with assisting consumers in navigating the process of accessing housing. Even though that process could, in and of itself, build therapeutic engagement with consumers, this was usually short-lived and could become counterproductive when consumer goals of acquiring adequate housing remained unmet and promises made by service providers were perceived as having been hollow.

5.4.5. A Broken Housing System: "No one wants her."

Service providers and consumers described what they experienced as a complicated, dysfunctional, and fractured supported housing system, unable or unwilling to respond to the high demand of the mental health system or to the individual needs of ACT consumers. My findings showed that despite the implicit assumptions of complexity necessary for ACT eligibility, these consumers were nonetheless perceived as unprioritized and were even discriminated against within the supported housing system.

other cases, these safety checks were justified in the context of the opiate poisoning crisis and the potential that a resident may be in medical distress inside their suite. Interestingly, these safety checks appeared to justify access to residences by building staff (and ACT service providers) without consent from the occupant.

Consumers almost uniformly expressed confusion regarding what they perceived as a maze of eligibility and access requirements necessary to secure supported housing in this setting, and they voiced frustration with what they saw as a lack of communication and transparency within that system. It was common for consumers to share vexation that even if they were able to identify a specific supported housing environment where they wished to live, the pathway to securing that housing was unclear and unnecessarily complicated with bureaucracy. Consumers also frequently described feeling completely disconnected from the decisions to match them with or exclude them from a given housing site. My findings from service provider interviews suggested a system where various levels of professional decision making weighed consumer suitability for housing. My data supported that service providers used discretion in the referrals they made to supported housing services; these were screened and matched to specific sites, and then housing providers at those sites used discretion in accepting or rejecting referrals. In other words, my findings showed that there were multiple levels of discretionary decision making that assessed the appropriateness or inappropriateness of a given housing referral, with consumers almost entirely removed from, or even unaware of, those processes.

Interestingly, my findings showed that ACT service providers were also frustrated with the complexities of navigating this system for ACT consumers, and that housing problems were worsening during the period of data collection (2016–2018). Service providers viewed these housing problems in systemic terms, with multiple layers of interconnected complexities associated with different stakeholders, including non-profit service providers, health authorities, municipal government, BC Housing, and privately owned SROs. Each of these stakeholders received criticism from service providers for discretionary decision making and for overt and hidden policies that precluded ACT consumers from tenancy or relegated them to substandard and temporary settings.

My findings revealed that even policies that on the surface appeared potentially beneficial to ACT consumers were actually unhelpful. For example, several service providers were highly critical of a municipal policy mandating that a percentage of tenants in newly constructed social housing buildings be homeless at the time of referral. The following data excerpt provides an example of this frustration: “And then [the municipality] is like ‘we’re going to fix this’ [homelessness], and they’ve made it worse. They’ve honestly made it worse. They took a really bad situation and made it hell” (ACT

14SP). This policy that mandated a proportion of rooms for individuals who were homeless would theoretically prioritize ACT consumers, given their rates of housing instability. However, service providers almost unanimously perceived that policies such as these added inflexibilities to already complex bureaucratic systems, and that other exclusionary criteria often precluded ACT consumers, despite their extensive histories of homelessness and housing instability. Service providers even described this policy as harmful because accessing these rooms designated for homeless consumers necessitated maintaining consumers in a state of homelessness throughout the application process. In other words, interventions to find these consumers housing while waiting, even if temporary or substandard, would preclude eligibility. In addition, because some of the rooms were designated for homeless individuals, this in turn decreased the number of rooms and increased competition for those consumers who were in some way sheltered.

Service providers also perceived that ACT consumers were often excluded from these suites due to stigma associated with previous behaviours, even if those behaviours had occurred prior to ACT enrollment and in the context of untreated or undertreated mental illness. Almost all service provider participants reported that historical behaviours of ACT consumers limited or eliminated housing options and overshadowed current functioning, treatment successes, and recovery. For example, one service provider shared:

One client sadly had been to tertiary, done really well, and then back to downtown [in substandard housing]. And she is so-called “difficult,” and the saddest thing is that no one wants her. Trying to find her housing, even at a shelter, as soon as they find out who it is, they’re like, “We don’t have room.” And it just . . . no one wants her. The hospital doesn’t want her. None of the housing we’ve tried to [get], and like low-barrier SRO, shelters, they don’t want her. (ACT 4SP)

This data excerpt also points to an important group of ACT consumers who had completed lengthy hospitalizations in tertiary treatment facilities or residential substance use treatment but could not be discharged to a suitable housing environment. Despite service providers’ perceptions that completing such programs should prioritize consumers for permanent housing options, and that consumers were often homeless or

unstably housed prior to admission, these consumers were frequently excluded from accessing rooms designated for homeless individuals. My findings suggested that such treatment settings were often interpreted by the larger system as “housing,” making consumers ineligible for the units reserved for homeless individuals. During my focused fieldwork, one consumer shared an experience of being intentionally discharged from a tertiary facility into homelessness so they could access a suite in a newly constructed social housing building. This consumer recalled receiving the options of being discharged to a decrepit SRO or to homelessness, with the latter option paired with an explicit plan of eventually acquiring a suite in a new building designated for someone “homeless.” This participant reported choosing to be discharged to homelessness, and they moved between several emergency shelters over a period of months, waiting for a room in the building. That consumer also shared frustration that they had originally entered the tertiary facility because of promises from ACT service providers that successful completion of treatment there would result in improved housing upon discharge.

These experiences were not limited to one consumer, and both service providers and consumers shared similar stories of discharge practices from tertiary facilities and residential substance use treatment to substandard housing environments or homelessness. Most of the consumers interviewed who had been to a tertiary facility reported that their discharge was to an SRO or supported housing setting in The Block, or to an emergency shelter. Service provider participants critiqued what they perceived as system-level decision making and policies that facilitated purposeful discharges of ACT consumers to substandard housing or homelessness after months or even years of tertiary facility or residential substance use treatment. Some service providers reflecting on such discharge practices saw them to be both financially “wasteful” and ethically questionable. ACT service providers also perceived that discharges to homelessness or unstable housing after stability usually resulted in predictable and preventable cycles of wellness while in tertiary care, followed by homelessness, psychiatric decompensation, and a return to hospital. The following service provider spoke to the need for a specialized resource to fill this housing gap:

If there was somewhere that someone could go . . . that was not the [SRO in The Block] or whatever, once they’ve achieved a little bit of stability. Like it’s insane that someone will just kind of keep going through that cycle where they kind of

stabilize a little bit, get a little bit of a break, kind of get things back on track and then we say “alright, you can go back to [SRO in The Block]” and then it kind of happens again and again and again. (ACT 6SP)

Service providers also spoke about the increased risk of opioid poisoning due to detoxification and reductions in tolerance after a lengthy admission to a tertiary hospital or residential substance use treatment, followed by discharge to a substandard housing environment. My findings showed that ACT service providers perceived these substandard environments to enhance the risk of opioid poisoning due to factors such as easy access to substances, predatory drug dealers, and previous social networks in these buildings, which normalized and facilitated a return to earlier patterns of substance use. Service providers also noted that discharge after an extended stay in tertiary was often accompanied by access to a relatively large sum of money from income assistance, which further enhanced risk by facilitating access to a larger quantity of drugs than a consumer could usually afford. Informal interviews also revealed that some consumers who were prescribed opioid agonist therapy (e.g. Methadone or Suboxone) prior to their admission to a tertiary facility had this prescription discontinued during their stay, increasing their vulnerability to overdose if they relapsed. The following data excerpt provides an example of a discharge from a tertiary facility:

That’s the discharge plan, yeah. So, they stay for months, maybe not engaging in programming but like in a clean, safe environment. Maybe using once in a while, but the frequency has gone down so you’re still able to have a conversation with them, but the discharge plan is to go back to The Block, which is . . . a disaster! Yeah! Like huge risk. (ACT 12SP)

In summary, my findings showed that service provider participants perceived treatment barriers related to housing instability and homelessness as being precipitated by deficient policies and practices at a larger system level and felt powerless to address these. Service providers experienced a foreboding “predictability of crisis” when consumers were relegated to inferior housing or homelessness, where barriers to treatment interventions and mental wellness were profound. The resulting cycles of improvement and stability through long-term residential treatment, followed by decompensation and crisis were experienced as predictable and yet preventable if adequate housing were prioritized or created for these high-needs ACT consumers. My

results also showed that the constricted housing options available after a long hospitalization or sojourn in residential treatment contributed to an enhanced risk of substance use-related harms.

5.5. Discussion

My findings provide rich detail of how homelessness and housing instability amongst ACT consumers shaped treatment experiences and health-related outcomes in a large BC municipality. Almost all of my consumer participants had experienced previous periods of homelessness, and at the time of being interviewed, nearly 25% were either homeless or residing in temporary emergency shelters. Similarly, all of my ACT service provider participants shared robust experiences of providing treatment to consumers living in homelessness as well as temporary and substandard housing environments. These experiences of both consumers and service providers, coupled with focused observational fieldwork, facilitated the collection of robust and descriptive data. My analysis identified several overarching themes through which I have presented my results: a city with no housing; transitional housing; trauma and the stigma of place; housing is a hook; and a broken housing system. Consistent with the social constructivist foundations of grounded theory ethnography methods, these themes were presented as interrelated discourses and when considered together present a cohesive picture of facilitators and barriers to ACT treatment linked with housing issues, from the perspectives of participants.

5.5.1. Fit with Previous Literature

Although ACT is recognized as one of the most extensively researched topics in community psychiatry, this body of literature is dominated by quantitative inquiry. A scan of what qualitative research has been conducted reveals minimal focus on housing experiences for either ACT consumers or service providers. This underscores the uniqueness of my findings as well as the need for further qualitative investigation into this domain of ACT treatment. However, this dearth of research also created a barrier to situating my results within the larger body of ACT literature. I therefore had to turn to other sources, such as housing-specific literature, where ACT is sometimes paired with interventions such as Housing First, to indirectly link my findings with other studies.

My findings build on earlier qualitative research describing the chaotic lives of consumers prior to ACT enrollment. Previous research has described poverty, homelessness, social dislocation, and violent victimization as contributing to the functional disability that precipitates ACT enrollment and creates barriers to treatment engagement (Cuddeback et al., 2011; Lamberti et al., 2014; Leiphart & Barnes, 2005; Pettersen et al., 2014; Thøgersen et al., 2010). My findings are also consistent with literature describing experiences of unmet basic needs (shelter, food, and personal security) prior to ACT enrollment, as well as stigma and societal marginalization associated with severe mental illness in general (Cuddeback et al., 2011; Estroff, 1981; Prince & Prince, 2002). My findings related to financial hardship linked with inadequate income security programs also build on previous research, which has described the financial marginalization of the ACT consumer population (Cuddeback et al., 2011; Estroff, 1981; Krupa et al., 2005). However, my results make key contributions to the ACT literature by linking the financial marginalization of ACT consumers with experiences of housing instability and homelessness, as well as with how these shape treatment experiences and outcomes.

My results show that homelessness and previous traumatic life events contribute to functional impairments experienced by consumers that can result in the eventual need for ACT enrollment. My results underscore the possibility that these life events could be focal points for early interventions that might change treatment trajectories for individuals with mental illness. My findings are important for showing that functional impairment is not an inevitability of serious and persistent mental illness, but rather an indication of systemic failures to support this population.

Previous research has found that housing stability for individuals with serious and persistent mental illness can provide benefits beyond shelter, through enabling consumers to self-identify and work towards long-term goals (Canham et al., 2017; Croft et al., 2018; Gaetz et al., 2013; Nelson et al., 2007). In other words, providing secure housing facilitates stabilization, after which consumers can capitalize on the supportive resources available to them (such as through ACT). This research provides context for my findings that unstable housing and homelessness create barriers to ACT service delivery and result in a perceived prioritization of medication-related contacts and crisis intervention responses rather than consumer-identified goals.

My findings call attention to the prevalence of a transitional model of supported housing and implicit assumptions that promoting the flow of consumers out of such supported living environments within a given period of time (two years) will produce better outcomes. Such assumptions are countered by previous research, which has emphasized the importance of permanent housing for ACT consumers (McPherson et al., 2018; Nelson et al., 2007). I found that this transitional housing model was experienced as destabilizing and a barrier to consumers forming social bonds with others. This finding is important to consider within the context of previous research, which has emphasized that increased social connections and role functioning are important components of ACT treatment (Angell, 2003; Angell et al., 2014; Appelbaum & LeMelle, 2008; Jochems et al., 2012; Kreyenbuhl et al., 2009; Leiphart & Barnes, 2005; Passetti et al., 2008; Redko et al., 2004; Smith et al., 2013; Stanhope & Matejkowski, 2009). I recommend that future research focus specifically on the role of transitional housing and its impact on social connection and social integration for ACT consumers.

The ACT model has shown efficacy for addressing housing and overall psychiatric treatment outcomes when combined with the evidence-based intervention of Housing First (Aubry et al., 2016; Goering et al., 2011; Padgett et al., 2006; Somers et al., 2013). North American research has shown that Housing First using the ACT model for clinical supports demonstrates a strong primary outcome of increased housing stability, as well as secondary outcomes of increased mental health treatment retention, higher adherence rates to antipsychotic medications, and reductions in criminal recidivism (Aubry, et al., 2016; Busch-Geertsema, 2014, Canham et al., 2017; Rezanoff et al., 2017; Roos et al., 2016). It is important to consider my findings within the context of this body of Housing First research and in particular a recent RCT conducted in five Canadian cities, referred to in this thesis as the At Home study (Goering et al., 2011). That Canadian research study saw approximately 2,500 participants randomized, based on needs, to different treatment options, with higher-needs individuals receiving Housing First in combination with ACT treatment (Goering et al., 2011). The At Home study ended in 2013, and despite positive research findings across its Canadian sites, BC has not implemented a comprehensive Housing First model within its mental health treatment system. Other researchers have identified barriers to Housing First implementation, such as limited availability of affordable housing, landlord discrimination, and inadequate social assistance rates (Canham et al., 2017). My findings are similar

but also add to this list through showing that a “housing readiness” model predominates in this setting and that it is shaped by system-level priorities and service provider assumptions. My findings have implications for policy makers and call into question current policies that restrict the potential therapeutic power of the Housing First model in this setting.

I could not find previous ACT research that has identified stigma associated with geographic spaces (such as The Block) as impacting ACT consumers and service delivery, as shown in my results. I therefore turned to other fields, such as public health and urban geography, where the term “territorial stigma” has been used to describe how spaces themselves can become focal points of marginalization and stigma that can transfer to residents (Collins et al., 2016; McNeil et al., 2015). Wacquant (2009) identified that marginalized spaces, labelled as “slums” or “ghettos,” can transfer their stigma to residents and mark them for unequal treatment within that space and outside it. My findings in this area appear to be unique and call for further research, following my lead in using the theoretical lens of territorial stigma to analyze the marginalization of ACT consumers.

5.5.2. Strengths and Limitations

Although previous research has recognized homelessness and housing instability as common attributes of ACT consumers, I could not find qualitative studies that have examined experiences specifically related to ACT treatment and housing issues. Therefore, a strength of my research is its engagement with this topic through the experiences of service providers and consumers. My findings are also important because of the environmental context of data collection: a municipality experiencing a housing crisis. These factors created a rich environmental context of housing-related experiences for both consumers and service providers.

My recruitment methods appear unique in the context of ACT research and are a strength of my overall approach. Instead of recruiting through ACT teams, which can introduce provider bias into the recruitment process, I utilized independent recruitment methods. I also did not exclude participants experiencing active symptoms of psychosis, so long as they were able to provide informed consent. Through these methods, I believe that I have accessed a perspective that has been largely absent from previous

qualitative ACT research. I assert that this voice is especially important because it likely represents a more marginalized subgroup of ACT consumers, and that future researchers should follow my lead.

Another strength of my research is the breadth of my data sources. I carried out focused ethnographic fieldwork as well as in-depth interviews with both service providers and consumers to provide deep contextual details of experiences related to ACT and housing. I note that previous qualitative research on ACT usually has focused upon one primary source of data and often has been limited to small sample sizes. Through recruiting a nearly equal number of service providers and consumers, I also avoided privileging the experiences of one group over another. My sample size further allowed me to reach data saturation on major themes, satisfying the requirements of the grounded theory ethnographic methods that informed my research.

My research also has limitations. Firstly, I chose not to assess the fidelity of these police-embedded ACT teams and instead assumed they were high fidelity. This limitation is important to note given that the embedding of police officers in ACT is a unique phenomenon that may pull these teams away from full fidelity. The ACT model has served as an anchor for my research and allowed for linkages with the larger body of ACT literature. If these police-embedded ACT teams are practicing with low fidelity, these linkages become tenuous. Secondly, my sample was purposely recruited from five teams in a large Canadian city, and caution should be taken in applying results to other contexts. However, I believe that the descriptive detail provided in my study has increased the cross-contextual applicability of my findings and reduced this potential limitation.

5.5.3. Conclusions

In a setting with limited housing options and increased competition for available resources, ACT consumers face multiple barriers to acquiring and maintaining permanent housing. Although Housing First has proven efficacy with ACT consumers in Canadian urban contexts, it is not a prominent model in this setting. Inadequate housing, housing instability, and homelessness impact the lives of ACT consumers and create barriers to ACT service delivery that in turn shape treatment outcomes. System-level prioritization of ACT consumers within the housing system is necessary in order to

counteract the multiple barriers that exclude them from accessing permanent supported housing. Investment in early intervention strategies may prevent the functional impairments, disability, and housing instability that eventually contribute to the need for ACT enrollment.

Chapter 6. Flow and Discharge from ACT

Abstract

Background: Assertive Community Treatment (ACT) is a well-researched, evidence-based model of community mental health treatment with demonstrated efficacy in reducing hospital utilization for a cohort of complex consumers characterized by severe mental illness and high psychosocial needs. Although ACT is an effective treatment intervention, it is also recognized for its intensity, intrusiveness, and substantial financial footprint. As such, ACT is usually reserved for the most complex consumers, and efforts have been made to facilitate the “graduation” of these consumers to less-intensive and less-expensive services once they have reached psychiatric stability. However, early research found that such graduation often resulted in rapid psychiatric symptom decompensation, a return to pre-ACT levels of function, and the need for tertiary treatment. This early research led to assumptions that ACT enrollment must be indefinite in order for consumers to maintain treatment gains. However, more recent research challenges these assumptions through findings showing that consumers can be successfully graduated from ACT if improvements are made to the larger treatment systems within which these teams operate. Despite growing recognition that successful ACT graduation is possible, the topic remains an underexplored frontier for ACT research, and many jurisdictions continue to enroll consumers indefinitely in costly and unnecessary ACT services. **Methods:** Drawing from grounded theory ethnography methods, I undertook 47 in-depth interviews with ACT service providers (N = 23) and consumers (N = 24), as well as conducting focused observational fieldwork to achieve a better understanding of barriers and facilitators to ACT graduation. Analysis of this theme focused on experiences from a subset of my participants (service providers) because results showed that consumers had little input into the admission and graduation processes of the ACT teams being studied. My participants were drawn from ACT teams in a large municipality in British Columbia, Canada, that are distinctive because they operate with the addition of embedded police officers and have implemented graduation practices since their inception. **Findings:** My findings are presented through a systems-level analysis showing that ACT intake and discharge practices are inextricably linked. My findings also emphasize how partnerships between

multiple stakeholders within an ACT model (such as police and mental health professionals) can contribute to competing priorities regarding which consumers should receive this finite resource. These competing priorities, and the consumer profiles they favour, shape the feasibility of eventual graduation as well as the overall treatment trajectories and flow in the larger treatment systems within which ACT teams operate.

Conclusions: My findings caution that adding embedded police officers to an ACT model can increase the complexity and heterogeneity of consumer profiles, enhance stigmatizing narratives of mental health consumers as dangerous, and create barriers to ACT graduation.

6.1. Background

Assertive Community Treatment (ACT) emerged over four decades ago to address the impacts of deinstitutionalization as centralized psychiatric hospitals began downsizing in the 1970s (Chen, 2006; Chow & Priebe, 2013; Markowitz, 2006; Prins, 2011; Watts & Priebe, 2002). At that time, large numbers of consumers with mental illness were discharged from hospital care to live independently in community settings where many were poorly served by existing outpatient treatment services (Chow & Priebe, 2013; Marx et al., 1973; Stein & Santos, 1998; Stein & Test, 1980; Watts & Priebe, 2002; Weisbrod et al., 1980). Deficits in community treatment combined with factors such as stigma, structural poverty, and social exclusion to produce a “revolving door” phenomenon of repeat hospitalizations and poor health outcomes for consumers with severe mental illness (Bond & Drake, 2015; Henwood et al., 2018; Stein & Test, 1980). The ACT model was created within this context, as healthcare systems and researchers sought to develop solutions to improve community treatment and reduce short-term hospital use for these “high-needs” consumers (Bond & Drake, 2015).

ACT is a well-researched treatment intervention that reduces hospital use and thus often results in financial savings to the healthcare system (Chandler & Spicer, 2002; Latimer, 1999; 2005; Salkever et al., 1999). ACT research has identified a set of key program structures and practices (fidelity measurements) that have come to define this treatment model, including multidisciplinary staffing, shared caseloads, 24/7 service delivery, and frequent contact with consumers through outreach into the community (Bond & Drake, 2015; Bromley et al., 2017). Additionally, within the context of inadequate community mental health resources in the 1970s, it was determined that ACT should be open ended or “time unlimited” in duration (Chen & Herman, 2012). Early research by Stein and Test (1980), co-creators of the original ACT model, found that consumers discharged from ACT quickly lost gains and returned to pre-ACT enrollment levels of symptom severity, disability, and high use of hospital resources. These early findings led to “time-unlimited services” becoming a central feature of the standardized ACT model (Bromley et al., 2015, 2017).

Early research found immense differences between ACT services and other community treatment options (often referred to as “treatment as usual”) available in North American contexts at that time (Chen & Herman, 2012). However, service delivery

gaps in many jurisdictions have narrowed since the 1970s, and alternative community treatment options (e.g., intensive case management) now routinely incorporate core ACT model interventions such as outreach, which have been associated with improved outcomes (Bond & Drake, 2015; Donahue et al., 2012). As the gap between ACT and other available mental health resources narrowed, contemporary research findings challenged whether time-unlimited services should be a key element of the standardized ACT model (Donahue et al., 2012; McGrew & Bond, 1995; Rollins et al., 2017). There was also growing recognition that providing lifelong ACT services to consumers contradicted the principles of psychosocial recovery¹⁶ and was financially impractical (Bond & Drake, 2015; Cuddeback et al., 2013; Salyers et al., 2011). ACT teams that incorporated time-unlimited service provision quickly reached capacity and then halted intake of new consumers (Donahue et al., 2012). By closing referrals into ACT when they reached capacity, these teams became siloed within their larger healthcare systems and were no longer accessible to incoming clients (Bromley et al., 2015; Chen & Herman, 2012; Donahue et al., 2012). A lack of consumer flow in and out of ACT, coupled with finite financial resources, resulted in treatment system stagnation, whereby an intact cohort of ACT consumers remained within this intensive service irrespective of their levels of need and functioning (Bromley et al., 2015). Consumers requiring ACT-level interventions therefore struggled in less-intensive services due to lack of flow into ACT, while consumers with improved symptoms and functioning continued receiving intensive, intrusive, and expensive services that they arguably no longer needed (Chen & Herman, 2012).

Although some recent research on ACT graduation has shown that it can be systematically implemented with positive results, the period of transition to less-intensive services has been recognized as a particularly vulnerable time for consumers, with the potential for psychiatric decompensation remaining high (Bromley et al., 2015; Chen & Herman, 2012; Watts & Preibe, 2002). Researchers have developed standardized tools to assist clinicians in determining whether an ACT consumer is ready to transition to a less-intensive service (Donahue et al., 2012). However, clinician attitudes challenging

¹⁶ A review of the literature shows that the concept of recovery in the mental health field is complex and that multiple definitions exist. I draw on a definition provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), which defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012).

the efficacy of ACT graduation remain a major barrier to the implementation of these tools and to ACT graduation itself (Bromley et al., 2015; Finnerty et al., 2015; Salyers et al., 2011).

While ACT has a long history as an effective evidence-based intervention, some jurisdictions have been slow to adopt this expensive treatment model. The geographic setting of this research, a city¹⁷ in British Columbia (BC), Canada, is one such example where the adoption of the ACT treatment model has occurred decades after its emergence in other jurisdictions. ACT teams in this setting have a relatively unique genesis associated with the advocacy efforts of municipal police departments that identified perceived gaps in the province's mental health treatment system. This advocacy pointed to deficits in care, resulting in an over-reliance on police resources, and called for collaboration between stakeholders through the creation of the police-embedded ACT model. Appetite for police-embedded ACT has been strong, and this adaptation has subsequently spread to several BC municipalities, including Victoria, Vancouver, and Surrey (Costigan & Woodin, 2018; Saltman, 2019; Szkopek-Szkopowski, 2013; Thompson, 2010; Victoria Police Department, 2017; Wilson-Bates, 2008). Similar to other jurisdictions that have implemented generic ACT, BC's police-embedded teams quickly reached capacity, and the intake of new consumers slowed (Szekopek-Szkopowski, 2013). Further police advocacy identified this lack of capacity to accept new referrals as another gap in care. Two potential solutions that have emerged in BC are early adoption of graduation practices by these police-embedded ACT teams and the creation of short-term treatment teams with embedded police officers, which can bridge consumers into ACT once capacity allows. Although there is some variation, these short-term treatment teams generally pair plainclothes police officers in one-to-one partnerships with healthcare workers to provide assessment and short-term treatment to consumers with high needs who would otherwise be referred to ACT if capacity existed (Szekopek-Szkopowski, 2013; Wiebe, 2016). In order to enhance confidentiality for participants, I have used the pseudonym Assertive Short-term Program (ASP) to identify this program and mask the specific location of data collection. In this research setting, the ASP team has a close relationship with flow into police-embedded ACT, and it

¹⁷ The actual geographic location of this research has been masked to increase confidentiality for participants.

provides pressure for ACT service providers to graduate consumers so as to allow new admissions.

In summary, although ACT graduation was unsupported by early research, contemporary analysis has shown that successful graduation is possible. However, ACT service provider resistance to graduation processes, along with consumer vulnerability in the immediate period after graduation, have been identified as potential barriers to the implementation of successful graduation practices. In this research setting, a unique ACT model with embedded police officers has been implemented with immediate pressure to employ graduation processes. As such, this setting provides a rare opportunity to examine graduation processes in relatively newly formed ACT teams. My research seeks to provide descriptive detail of the graduation processes of these police-embedded ACT teams and how the embedding of police officers may be shaping these processes and participants' experiences. The overarching question that guided the research detailed in this chapter asks how embedded police officers within an ACT model shape treatment experiences and outcomes related to ACT graduation.

6.2. Methods and Methodology

My research is informed by a qualitative research method known as grounded theory ethnography. Grounded theory ethnography merges elements of traditional grounded theory with ethnographic data collection that is focused on phenomena rather than setting (Babchuk & Hitchcock, 2013). Grounded theory ethnography evolved from "constructivist grounded theory," which endorses more flexibility than the arguably rigid methods of traditional grounded theory (Charmaz, 2006). Grounded theory ethnography embraces features of traditional grounded theory such as in-depth interviews, the constant comparative method of analysis, theoretical sampling, and coding saturation, and its overall goal is to generate descriptive theory about a given phenomenon (Charmaz, 2006, 2009). A central reason for the flexibility found in grounded theory ethnographic methods is its social constructivist foundation. Social constructivism postulates that multiple discourses exist about any given phenomenon and that these are necessarily shaped by the world views of those experiencing and making meaning of them (Chamaz, 2006; Creswell, 2018). Social constructivism also assumes that alternative discourses exist about the same phenomenon but that a strong (dominant) discourse will often subjugate these alternative views (Creswell, 2018; Madigan, 2011).

Social constructivism also views the research process as intertwining the researcher with the meaning-making process of their participants, with the end result being the formulation of a shared discourse of a phenomenon (Charmaz, 2006; Taylor, 2018).

Data for this research project were collected through 47 in-depth interviews with service providers (N = 23) and consumers (N = 24) as well as focused ethnographic fieldwork and informal interviews. As analysis progressed, my findings suggested that consumers were largely excluded from the enrollment and graduation processes of the police-embedded ACT teams that were the focus of this research. This theme therefore draws upon only service provider interviews and observational fieldwork.

Recruitment of service providers for in-depth qualitative interviews was selective and facilitated through a poster forwarded by email list-serve. This poster provided a brief description of my study and stated the inclusion criteria, which required potential participants to have at least one year of experience working with an ACT team that operated with embedded police officers. I also used snowball sampling techniques to expand my recruitment to former ACT service providers who had subsequently left employment with these teams. The 23 in-depth interviews lasted 40–90 minutes and were conducted at a variety of locations, including offices, coffee shops, restaurants, vehicles, and community centres. No honorariums were provided for participation in these interviews as they were considered within the scope of service providers' professional role.

My sample of ACT service providers ranged in age from 31 to 63 years of age (mean = 43 years). Fourteen of my participants were male and nine were female. Participants had between one and seven years (mean = 3 years) of experience working on an ACT team. Participants had two to 35 years (mean = 11 years) of total work experience in their given occupation or profession. My sample of service providers included physicians, nurses, social workers, occupational therapists, concurrent disorders counsellors, police officers, and peer support specialists. Participants included individuals from five police-embedded ACT teams, with some participants having experience working on multiple teams. A small portion of my participants also had experience working on ACT teams in other jurisdictions, which facilitated comparisons between police-embedded ACT and the traditional ACT model.

I also undertook over 90 hours of focused observational fieldwork and engaged in informal interviews with consenting participants within the most concentrated geographical service delivery area of these teams. This fieldwork was conducted in public spaces of The Block, a pseudonym for a neighbourhood in a large urban centre in BC often characterized by the social, economic, and spatial marginalization of its residents (Boyd et al., 2015; Boyd & Kerr, 2015; McNeil et al., 2015). I also received permission from a non-profit housing provider in The Block, described in this research as the Community Support Society (CSS), to undertake observational fieldwork in a supported housing building where a number of ACT consumers lived or visited. A verbal script was used to identify myself and to obtain informed consent during this fieldwork. I took written notes and used voice memos to document fieldwork, and these were used as a primary data source as well as to enhance contextual understanding and inform the analytical direction of ongoing in-depth qualitative interviews.

Although presenting characteristics of individual participants (e.g., gender, profession, experience) along with quoted text would provide readers with additional contextual detail, I have chosen instead to use an approach that enhances confidentiality. I assigned a numerical code to each participant and converted potentially identifying details of participants to aggregate form. Consistent with the social constructivist underpinnings of my research methods, I present my findings using terms such as “many,” “most,” “some,” and “few” rather than assigning numerical values to a given theme or subtheme. Through presenting my findings in this manner I hope to provide readers with a sense of the strength of a given theme while avoiding positivist assumptions related to the certainty of findings based on numerical strength or percentage thresholds.

Interviews were audio recorded, transcribed, and uploaded to NVivo 12 qualitative software to facilitate analysis. After all interviews were completed and transcribed, I developed an open coding framework collaboratively with two members of my PhD committee (Dr. Small and Dr. Jenkins). This coding framework was applied to all transcripts, allowing for the identification of major themes and subthemes across data sources. Axial coding was then employed to link findings and to enhance contextual detail (Corbin & Strauss, 2008). Through this axial coding process, I found linkages both within and across major themes. A process of selective coding was then used to identify the “core variables” and to create a cohesive storyline through which to present my

findings (LaRossa, 2005). A process of draft writing was used with the intent of developing descriptive theory about the overall phenomenon of embedding police officers in the ACT model (Charmaz, 2006).

6.3. Findings

My findings build on the limited qualitative research examining ACT graduation (discharge) practices. Although initially intending to focus upon graduation exclusively, my findings led to a broader systems perspective that necessitated I examine “flow” toward ACT (intake) as well as out (graduation), and how these processes influenced each other. In the initial stages of this research, I conceived of graduation as a consumer successfully transferring from ACT services to an alternative level of care. However, consistent with my inductive methods, my findings led me to expand this definition to a broader view of graduation, inclusive of all flow out of ACT services, irrespective of whether a given consumer met treatment goals during their tenure with ACT. My findings also called attention to the relationships between ACT teams and the larger healthcare systems they operated within. My analysis included exploration of both facilitators and barriers that shaped intake and graduation. While my findings showed that the unique collaboration between police and mental health services had implications for flow, many of my findings were also applicable to ACT teams operating without embedded police officers because they spoke to larger system processes that would exist in any healthcare setting with finite resources.

I nested my findings under several broad themes: intake and politics, graduating the “poor-fit” consumers,” discourses of dangerousness, and service provider attitudes. My findings provide a glimpse into the inner workings of police-embedded ACT teams and build on previous research examining ACT graduation.

6.3.1. Intake and Politics

For my participants, flow was experienced as both towards ACT teams and away from them. Flow into an ACT team was generally described by participants as “intake,” “referral,” or “enrollment,” and flow out was most commonly referred to as “graduation,” although terms such as “discharge” and “failure” were also used. Most of my participants viewed intake as inextricably linked with graduation, similar to a system seeking

homeostasis, with pressure to intake new consumers impacting decisions about graduating others and vice versa. Participants shared concerns that the complex heterogeneity of ACT consumer profiles in this police-embedded model created barriers to graduation and hampered their ability to enroll new consumers.

Although these relatively newly formed ACT teams had incorporated graduation planning and processes from their inception in 2012, many of my participants were unclear as to the actual criteria that should be used for intake or graduation. My findings showed that participants partially attributed lack of clarity about admission and discharge criteria to inadequate staff training in the ACT model itself, but they also felt enrollment and discharge criteria were moving targets. Most participants viewed intake and discharge criteria as malleable and attributed this to system pressure for ACT to quickly enroll consumers when new teams were created, followed by more stringent intake criteria when the teams reached capacity.¹⁸ Some of my participants shared feelings of lacking control, compassion fatigue, and burnout related to this perceived fluidity in enrollment and discharge criteria, the heterogeneity of complex consumers that resulted, and the sense that admissions were rushed. The following data excerpt provides context:

Once the pressure comes from above, sometimes we don't have a choice but to do the best that we can. It does have an effect on staff on the team; people get burnt out, people find it difficult to cope with what's going on. It is very common that we can have (the intake of) three patients in two weeks and people don't know who is who, can't remember who said what about who, and there is confusion. And it is hard, really hard. (ACT 20SP)

The creation of the first police-embedded ACT team in this setting was soon followed by additional funding to expand and create more teams. At the time of my data collection (2016–2018), there were five police-embedded ACT teams operating at maximum capacity in this setting. Service providers recalled that when each of these teams was created, there was significant systemic pressure to expediently fill the team with consumers. I found that the rush to fill these teams was perceived by service provider participants as contributing to the intake of consumers who may not be

¹⁸ My findings suggest that the maximum capacity of these teams has fluctuated over time, but during the period of data collection the capacity was seen as being 70 consumers per team.

considered typical of ACT. In the words of one participant: “I think looking back, there is a percentage of that caseload that would never get on an ACT team if they were being presented now” (ACT 25SP). Participants noted characteristics such as being too young, not yet having failed at conventional treatment, and having primary presenting problems related to substance use or high police contact rather than severe mental illness. I also found that the rapid intake of consumers to these newly established ACT teams occurred despite perceptions that intakes were too fast and led to a “crisis response” style of service provision, characterized by several participants as “putting out fires.” The following participant provided descriptive detail:

The other issue is that the way the ACT teams are formed here, it was to address a crisis issue, it was to address the violent incidents that were happening . . . after the closure of Riverview. . . . And also it was the push of [the police department] and [the] City that said we have to have this [i.e., police-embedded ACT]. So, it became more or less a crisis issue to deal within the mental health system. . . . And if that’s the purpose then you deal with the crisis and once the crisis is over, you’re done. You go and pick up the next crisis. (ACT 19SP)

This excerpt is important in part because it highlights a perception I frequently heard from participants—that the creation of these police-embedded ACT teams did not resolve the crisis but merely shifted responsibility for it from policing toward mental health service providers. The excerpt is also important because of the way this participant described collaboration between multiple stakeholders involved in the creation and expansion of police-embedded ACT in this setting. Related to this, almost all participants reported that their teams experienced “political” pressure to intake new consumers even if they were seen as a poor fit for ACT treatment. Although participants described a formal intake process through which most consumers were screened for admission, it was also common to hear examples where service providers perceived that this formal system was bypassed, or that it privileged certain referral sources. The following participant provided an example:

“You [the ACT team] are just taking them!” And my interpretation of that is that this individual is costing the healthcare system a lot of money and the system’s response to that is to put them on an ACT team. (ACT 1SP)

This participant went on to describe how in such “forced” admissions, the consumer was sometimes atypical for ACT treatment (e.g., did not have confirmed mental illness). Despite the absence of a mental health diagnosis, these “forced” admissions were usually associated with highly complex consumers who were intensely involved with multiple systems of care (i.e., criminal justice, mental health, emergency healthcare). The following data excerpt provides a critical assessment of the ramifications of these forced admissions:

But it’s the optics again, right? It’s very political. . . . So it feels like . . . I’m being played. I’m making this work for other people, because it looks good for [the health authority] and it reinforces this nice little alliance between [the police] and [the health authority]. That they can partner as stakeholders and they can provide services for some of the difficult people in the community. . . . It’s outrageous, what we have to do. So, there’s a fundamental . . . disconnect between being asked to provide services for clients under a model that was designed not for the population that we’re working with, and we’re not given any real tools to adjust what we need to do. (ACT 2SP)

This participant, along with several others, spoke directly to concerns about collaboration between police and psychiatric treatment providers and associated it with fundamentally altering the ACT model, and consumers, by adopting a more criminal justice or “forensic”¹⁹ focus. For these participants, most of whom had years of previous clinical practice experience, there was a perception that they were ill equipped in training, resources, and support to work effectively with these complex forensic consumers. There was also a notable perception that this collaboration resulted in unrealistic expectations that the ACT model could address the criminogenic risk factors of these consumers.

Most of my participants also believed that the municipal police force their teams were partnered with was privileged in the referral process to ACT and that this influenced the profiles of consumers enrolled in the program. Some of my participants

¹⁹ Here, the term “forensic” refers to the forensic psychiatric system, a formal system that operates at the interface of psychiatric treatment and the criminal justice system in the province of BC. Forensic consumers are mandated to treatment through the criminal court system and are usually treated through this separate system (forensic psychiatric services) rather than the civil mental health system.

had experiences dating back to the inception of police-embedded ACT in this setting and recalled that the initial referral system had been almost entirely directed by police. One participant explained in more detail:

The process at the beginning . . . was completely directed by the [police] through an analyst who would identify people who were presenting on the streets to patrol [officers] . . . under the reason “emotionally disturbed person.” The analyst would . . . tally-up . . . how many contacts they’ve had under that category and then they would make a referral [to ACT] . . . (ACT 16SP)

Several participants expressed concerns that this original intake system, with law enforcement controlling the selection of referred consumers, privileged policing priorities. Some also noted that this foundation continued to shape the ACT treatment culture such that high police contact had become a marker for dysfunction, eclipsing more traditional measurements of mental health needs, such as previous treatment failures and severity of symptoms. My findings also suggested that many participants viewed reductions in police contacts for ACT consumers as having been inappropriately positioned as a system-level measurement of success for these police-embedded ACT teams. The majority of my participants disagreed with this criminogenic outcome prioritization and viewed psychiatric outcomes as better measurements of treatment success. Further, my results revealed critiques that if ACT treatment was reducing police contacts for consumers, this was likely achieved by shifting police contacts from patrol officers to the officers embedded within these ACT teams. In other words, police contacts with ACT consumers were not actually reduced but were merely being recorded or presented differently.

While participants expressed that the referral process to ACT had changed since its inception and that a more rigorous, health-focused screening had become prioritized, most participants believed that the police in this setting still had an indirect influence on the intake of ACT consumers through their collaboration with a short-term treatment program (ASP) that funnelled consumers towards ACT. The following data excerpt provides context:

I think it’s [i.e., police influence] a bit more covert than it used to be because it’s now more connected to [ASP]; like, a lot of our referrals come through [ASP], a

lot of them. And there's definitely internal pressure to prioritize the referrals—like, if one comes through the pipe there's not a lot of questioning and that's just, we have to take them. . . . That's something we don't talk about enough, I think. . . . It's not directly (the police) saying "you gotta take this guy, he needs it." But it's subtly through that direction . . . which is kind of interesting. (ACT 22SP)

This participant later shared that ASP referrals were privileged not only for admission, but also for much faster transfer to ACT than those from other sources. This was experienced as contributing to rushed intakes of complex consumers who would benefit from a lengthier bridging process between services. A participant provided an example:

If it's a referral from [ASP], their discharges are quite quick whereas ACT standards are for slow intake over a month and sometimes that's half, it's way less, it's like a week, maybe less than a week. . . . Often at times we'll do like one, maybe two joint visits with [ASP] if we're lucky and then it's like, "okay they're completely yours." [With] mental health teams²⁰ I feel there's a little bit more transitioning in terms of going to do joint visits and there's more of a conversation about the client's needs and how they are, more of a conversation, like letting the client know that this transition is happening to ACT . . . (ACT 12SP)

Notably, this participant also emphasized that some consumers were not even aware of the referral or transfer to ACT until it was actually occurring. Participants stressed that an extended transfer period provided an opportunity for different ACT service providers to engage with consumers, form therapeutic relationships, and elicit consumer-identified treatment goals, without the burden and responsibility of assuming all aspects of care. This was especially the case with consumers mandated to treatment through the provision of mental health legislation who were likely not in agreement with some aspects of their treatment plans, such as medication administration. Participants noted that quickly assuming responsibility for medication administration prior to forming

²⁰ The term "mental health team" refers to a traditional office-based case management treatment team. Mental health teams have been the standard community treatment model for individuals with serious and persistent mental illness in several BC municipalities since before Riverview Hospital began downsizing. Within the BC community treatment continuum, mental health teams are the next level of community-based treatment below ACT teams.

a therapeutic relationship often led to increased conflict with consumers and negative initial experiences with ACT enrollment.

My findings revealed a strong theme of participants perceiving that police-embedded ACT in this setting had become a “catch-all” or “silver bullet” intervention expected to produce positive results in any complex consumer. For many of my participants, this expectation was experienced as resulting in ACT referrals for consumers who were poorly serviced because of gaps in care in the current treatment system, but who were not necessarily a good fit for ACT. I found that many participants felt there was an expectation that by “forcing” these consumers into ACT, their immediate treatment needs would be met and there would be a trickle-down effect for other parts of the treatment system, which would provide services when the consumers were ready for graduation. The following excerpt shows frustration related to such gaps and the assumption that the implementation of ACT alone would address them:

You aren’t getting the entire service to step up and deliver care in a different way! You can’t be 9 to 5 Monday to Friday, because people *do* get sick on Saturday, and on Sunday, and after hours. If the entire service isn’t augmented and expanded, then you’re going to just keep failing because one service [i.e., ACT] can’t save everybody. (ACT 16SP)

This excerpt refers to distinctions between ACT services that are provided seven days a week and services of lesser intensity, such as mental health teams, which operated Monday to Friday in this setting. The view expressed here and by most of my other participants was that treatment system changes based on the creation of a single program (such as ACT) were insufficient to close system-level gaps in care. Indeed, they were seen as creating unrealistic expectations for the program and its service providers.

Almost all of my participants provided examples of working with consumers who were experienced as being “forced” on ACT, despite service providers perceiving them to be a poor fit. In presenting my findings, I use the term “poor-fit” consumers to identify this broad category. Most of my participants perceived that being forced to take these “poor-fit” consumers demoralized staff, decreased potential for positive treatment outcomes, led to disproportional allocation of resources to these consumers, and reduced the likelihood of their eventual graduation to other services.

Most of my participants referred specifically to the absence of an “Axis I” diagnosis or the prominent presence of an “Axis II” diagnosis when describing these “poor-fit” consumers. These terms were categorizing language derived from a now obsolete version of the Diagnostic and Statistical Manual (DSM).²¹ Many of my participants used Axis I and Axis II as shorthand in their descriptions of ACT consumers, and Axis II was commonly used as a term of exclusion to describe consumers perceived to be a poor fit for ACT. The following data excerpt provides an example:

Clients get referred who don’t necessarily have an Axis I. . . . We’ve had clients with Axis II disorders. I think part of the issue is that there’s not a rollout in terms of criteria, from what I understand. So, it’s [i.e., ACT] almost like a catch-all. (ACT 2SP)

This data excerpt is also important for emphasizing that the participant was unaware of there being specific admission criteria for ACT consumers. I found it notable that although most of my participants identified the intake of these “poor-fit” consumers as a profound issue for their respective teams, very few referred to the BC ACT standards that speak to characteristics that ACT consumers should have. In fact, when participants were asked about the BC ACT standards, only a small number were even aware they existed. In brief, the BC standards specify that ACT consumers should have a diagnosed serious mental illness, *and* functional impairments (e.g., unemployment, housing instability), *and* high use of hospital resources, *and* high service needs (such as intractable major psychiatric symptoms, concurrent substance use disorder, or difficulty engaging with office-based treatment services).

I found that definitions of poor fit also included criteria that a given consumer lacked or did not display. Examples included referrals for consumers who did not have high rates of hospital use prior to referral to ACT, or lacked a substance use disorder history, or had no history of housing instability or homelessness. Another grouping of

²¹ The DSM, referred to by some of my participants as the “bible” of psychiatry, contains a diagnostic and classification system of mental disorders. Prior to 2013, when the DSM-5 replaced the DSM-IV TR (Text Revision), a five “Axis” system was used to categorize the diagnosis of mental disorders. Axis I disorders included broad categories such as mood, anxiety, and psychotic disorders, and Axis II included personality disorders and what is now called intellectual disability.

these “poor-fit” consumers was those referred to ACT with a primary²² presenting problem that was perceived to be difficult to treat through pharmacological interventions. Participants shared examples of referrals for consumers who had primary issues related to fetal alcohol spectrum disorder (FASD), developmental disorders such as autism spectrum disorder (ASD), acquired brain injury, severe behavioural and emotional dysregulation, and specific personality disorders (such as borderline personality disorder and anti-social personality disorder). Participants described gaps in care for conditions such as these, which were perceived as making ACT the only treatment option available. In other words, ACT became a “catch-all” for consumers for whom there was no appropriate secondary (specialized) treatment option.

One of my service providers shared examples illustrating the characteristics of “poor-fit” consumers:

We’ve got a guy who is autistic and would never touch drugs and I don’t know how he’s on our team, but he is on our team. We’ve got a woman who has some mental health challenges but, I don’t know if it would qualify under an Axis I, and she would never use drugs or drink or smoke or do anything like that . . . both of them got assigned separately to our team. She was assigned because of a very violent incident in a hospital; one of the nurses was badly burned. (ACT 1SP)

This excerpt is also important because of the participant’s perception that this consumer was referred to ACT because of an act of violence. The participant went on to describe that in both of these cases, ACT enrollment was “required” due to service gaps, as no other community-based treatment options could provide consistent follow-up. It was also notable that in both of the above examples, the consumers were referred while in hospital, and their discharge to community was being delayed because no appropriate treatment resource could be identified.

There were also several participants who shared beliefs that ACT enrollment had a counter-therapeutic effect on some of these “poor-fit” consumers. In particular, participants emphasized difficulties with fit between ACT treatment and consumers who

²² Participants used the term “primary” problem to describe what was perceived to be the most important or prominent condition (or issue) that a consumer was dealing with, while acknowledging that most ACT consumers have multiple co-morbid issues or conditions.

exhibited low impulse control, complex trauma histories, and personality disorders. The following participant provided an example:

They were never an appropriate ACT fit. It was strictly a personality [disorder] presentation, which is trauma based. But still, if you've got the . . . more cluster B₂₃ personality [disorder] and you've got 10 clinicians to play with, you're going to play. And unless those clinicians are really tight on the same page of what to say to this person, it's a mess. And it was a mess, and we made it worse for that person. For all of those folks. . . . Just ramped up the symptoms, ramped up the attachment, abandonment, visits to hospital, suicidal ideation, yeah. That wasn't good. (ACT 5SP)

Several of my participants shared concerns similar to those in this excerpt, describing that for some of these “poor-fit” consumers, ACT treatment actually increased the use of hospital resources. Although my findings showed that ACT consumers in this setting often had comorbid Axis I and II disorders, consumers with *only* an Axis II disorder were almost universally perceived as a poor fit for the ACT model by most service provider participants. In some cases, as noted by the previous participant, ACT's team-based service delivery, with multiple service providers having separate contacts with a consumer in a short period of time, was seen as counter-therapeutic for individuals with personality disorders.

Most service providers who shared experiences related to this theme highlighted perceptions that one of the key features of ACT referrals should be the “treatability” of a psychiatric diagnosis. Although some participants experienced treatability broadly and as inclusive of interventions that targeted reducing substance use, addressing homelessness, reconnecting with family, and obtaining employment, my findings emphasized that the concept of treatability usually privileged potential responses to pharmacological interventions. Most participants perceived pharmacological therapy as a litmus test for ACT appropriateness, and those not requiring or not responsive to medications were viewed as largely inappropriate for ACT:

²³ When this participant referred to “cluster B,” they were speaking about one of three groupings of personality disorders that were formerly categorized under Axis II of the DSM. The participant later indicated they were specifically speaking about consumers with a primary problem of borderline personality disorder.

No, he won't take anything [i.e., medications]. So, he's been voluntary. He doesn't want to engage. . . . But looking back, like, I don't think he should have ever have come to ACT to begin with, because the history clearly shows that [his symptoms are] . . . a result of substance use and you're not going to change that. . . . There's nothing that ACT can do for him. (ACT 25SP)

This participant spoke to a segment of ACT consumers whose psychiatric symptoms appeared directly related to substance use rather than an underlying mental illness such as schizophrenia or bipolar disorder. My findings called attention to tension between service provider participants with regards to this cohort of ACT consumers. The majority of participants viewed these consumers as inappropriate for ACT treatment because their symptoms cleared quickly in hospital in the absence of substances and without the use of pharmacological interventions. But other participants believed that treatment through ACT (specifically, pharmacological treatment) could prevent or reduce these symptoms, even in the face of ongoing substance use. Further, a select group of my participants viewed substance-induced psychotic symptoms as almost impossible to disentangle from primary psychotic illness (such as schizophrenia) and therefore regarded as largely irrelevant any attempts to differentiate between the two.

I found that service providers experienced a sense of futility about working with the “poor-fit” consumers, for whom they perceived there to be no evidence-based pharmacological intervention. The previous excerpt also spoke to another belief a number of participants appeared to hold: that clients who were not certifiable under the BC Mental Health Act were inappropriate for ACT. In BC, certification requires that four criteria be met, including that a person has a “treatable” serious mental illness that cannot be addressed through voluntary treatment. My findings suggested that voluntary consumers, who did not meet the threshold for certification and who also refused psychotropic medication, were viewed by most service providers as being inappropriate for ACT. Although I sought more specificity from my participants, this view appeared to be rooted in treatment culture rather than based upon an interpretation of the ACT model's standards or on research evidence.

Almost all participants perceived that their teams enrolled large numbers of consumers with criminal justice or forensic histories who were previously precluded from treatment through the civil psychiatric system. My findings showed that although some of

my participants used the term “forensic” specifically to describe consumers with formal forensic psychiatric system involvement, others used the term loosely as inclusive of ACT consumers with criminal justice system involvement or histories. In other words, for some of my participants, the term “forensic” was synonymous with the confluence of mental illness and criminal justice system involvement, irrespective of actual forensic psychiatric system history. Most of my participants perceived the ACT model to be poorly suited to treat these forensic or criminally involved consumers. However, most also believed that the embedding of police officers in the ACT model created an expectation that these teams should be capable of doing so, which in turn privileged ACT referrals for this population. The majority of service providers in my study perceived that expectations that police-embedded ACT had the capacity and resources to effectively treat this population were incongruent with their experiences.

Only a small number of my service provider participants perceived ACT enrollment for these forensic or criminally involved consumers to be positive. However, most pointed to gaps in care related to this population and noted that without police-embedded ACT, these consumers would be undertreated or untreated within this setting. One of my participants provided this perspective:

One of the biggest things we find is, and then you're labeled a forensic client, and then all these systems try to back away, and the forensic system wants the civil system to take over when they're no longer a forensic client, but the civil system is reluctant to do so because they're a forensic client. . . . What we're saying now is . . . those are exactly the type of people we should be focusing on. (ACT 9SP)

This excerpt underscores a view common amongst most of my participants: that prior to the emergence of ACT in this setting, there was a subgroup of consumers cycling through distinct episodes of treatment mandated under criminal court order (e.g., probation), followed by treatment disengagement when such court orders expired. My results showed that once these limited terms of mandated treatment ended, the lack of integration between the forensic and civil psychiatric systems, coupled with perceptions that these clients “belonged” in the forensic system, created barriers to treatment continuity. While my findings showed that police-embedded ACT had targeted these consumers, their enrollment was nonetheless contentious for the majority of participants, who distinguished between mandated treatment initiated by a physician under the

Mental Health Act (civil system consumers) and mandated treatment initiated by a judge as a result of criminal activity (forensic system consumers). For these participants, forensic system consumers were seen as *requiring* forensic system treatment resources even if their court orders had expired.

In summary, I found that participants viewed intake and graduation processes to be interrelated and that pressure to intake new consumers was inextricably linked with a need to graduate others. My findings showed that pressure exerted on the intake side of this system was experienced critically by most participants, especially if it was perceived as bypassing the typical ACT referral process or criteria used in this setting. Participants used the term “political” to describe some of these referrals, and my findings also pointed to concerns that the police have had both direct and indirect influence over the profiles of consumers enrolled in police-embedded ACT. Most participants also believed that police-embedded ACT in this setting has been errantly perceived as a “silver bullet” intervention that can enroll almost any complex consumer and produce positive outcomes, whereas my participants assumed that for ACT to be successful, it should be reserved for consumers with specific profiles. Service providers perceived that some consumers were forced into ACT due to gaps in care and that these consumers, although complex, were a poor fit. I clustered these consumers under the category “poor-fit” and noted that their primary problems were often conditions that participants perceived to be poorly treated with medications. Characteristics of poor fit included problems such as FASD, ASD, personality disorders, and traumatic brain injury.

6.3.2. Graduating the “Poor-Fit” Consumers

I found that the same characteristics that participants pointed to as distinguishing some individuals as “poor-fit” consumers were also attributes that created barriers to ACT graduation. Participants who shared experiences of trying to graduate these “poor-fit” consumers lamented that there had not been a way to block these referrals, as they were experienced as having negative impacts on the participants, their colleagues, and the consumers. The following data excerpt provides a robust descriptive analysis of this issue from the perspective of a service provider:

They [i.e., graduations] feel messy, they feel unfinished, and they feel ethically questionable. I haven’t felt good about it, but I also know there’s nothing we can

do more for the people. . . . There are folks that we took on quite a while back and always political, never because they fit the mandate. . . . They were assigned to us . . . Axis I wasn't there. One client, I remember specifically, 100% no Axis I. Huge personality [disorder] presentation. Not a fit for ACT, not a fit, not even a little bit. . . . A shit show from the get-go. Eventually we had to discharge him. There was no graduation; it was just a straight up discharge because there was nothing we could do for him. We couldn't keep him out of jail, we couldn't keep him safe, we couldn't keep him healthy, and he's expiring now. He's dying because there was just nothing we could do. We did three years with him, burned out almost everybody on the team. . . . But again, it was graduation because after so many years, we're not going anywhere with this person and in fact, we're making it worse. We made it worse for actually a number of folks that should have never come to ACT. (ACT 5SP)

Graduating these "poor-fit" consumers was experienced as difficult due to their lack of fit within the larger system of care. My results showed that although there was perceived pressure for ACT to modify its intake criteria to accept these consumers, participants experienced that lesser-intensity services appeared able to resist such requirements, which in turn created barriers to graduation.

My analysis also showed that some ACT consumers were experienced as being so profoundly psychiatrically unwell that they would never improve to the point of being ready for graduation. My findings showed that these consumers appeared to "stagnate" within ACT in a static but low level of recovery yet remained too acute to be graduated to a lesser-intensity service. The following data excerpt provides context:

You're not going to graduate her. She's just not going to, like you can't even get her stable housing, you're not going to graduate her. So, you need to look at what are you going to do when you get people like her and a little bit more stable, less chaotic and in a manageable place, not in a mental health team kind of way, but in a more manageable way, like what do you do then? Do you just keep them on ACT and suck the resources out of ACT? Or where do these people go? And that's the question. (ACT 8SP)

This participant later clarified that when referring to a “mental health team kind of way,” they were speaking about admission criteria for a mental health team (a less-intensive service in the treatment continuum). To paraphrase, this participant was stating that even with improvement, the “poor-fit” consumer was unlikely to reach a point where their presentation matched the support and services that a mental health team could provide.

In summary, I found that participants felt police-embedded ACT in this setting had flexed intake criteria to enable the enrollment of complex consumers with primary presenting problems such as FASD, ASD, and personality disorders. However, these consumers were seen as a poor fit for ACT treatment and the larger civil mental health treatment system. My results showed that these consumers were experienced as difficult to treat, and participants called attention to system-level barriers to graduating these “poor-fit” consumers to lower-intensity services, in part because other services had not matched the flexible admission criteria required of ACT. I found that even if these “poor-fit” consumers made improvements through ACT treatment, their enrollment was nonetheless experienced as negative because of the inability to successfully graduate them to other services. Instead, these consumers were either maintained indefinitely within ACT or “discharged” to inadequate services or no services at all.

6.3.3. Discourses of Dangerousness

My findings showed that ACT consumers were stigmatized and perceived as dangerous and that this created barriers to flow within the mental health treatment continuum. Almost all of my participants shared beliefs that a high percentage of police-embedded ACT consumers had criminal justice system or forensic system histories and that this feature created barriers to graduation due to perceptions of associated dangerousness. Most of my participants also shared perceptions that providing treatment to at least some of these consumers was inherently “dangerous” due to previous instances of violence or perceived risk of future violence. Interestingly, service providers shared that it was often information shared by the embedded police officers within their teams that called attention to this background, or at least confirmed suspicions or vague information known to service providers. Several of my participants believed that this information sharing (between police and ACT service providers) was vital for conducting their work, but my findings also called attention to the potential stigmatizing impact that this information could create when shared and documented

within a consumer's health record. My findings suggested that this impact was heightened when ACT consumers were being referred to other treatment programs as part of the graduation process.

My findings uncovered an interesting paradox related to the concept of dangerousness, whereby many participants perceived dangerousness in treating some ACT consumers while simultaneously seeing fault when other programs expressed the same concerns. I found that when other programs perceived ACT consumers as inherently dangerous, these same ACT service providers viewed those generalizations of dangerousness to be unfair, unjustified, and contrary to the principles of recovery. One ACT service provider described pushback related to preconceived notions of dangerousness being generalized to all ACT consumers when the participant was trying to graduate a consumer to lower-intensity services:

We wanted to discharge him to one of the other teams . . . the staff from this mental health team were clearly unimpressed and upset and fearful that this person was an inappropriate referral, "they're dangerous, blah, blah, blah"; all sorts of complaints. It was a very unpleasant meeting because they [were] super pissed-off that we had referred, and [they] wanted to refuse the referral. And I was like . . . "your concerns that you're expressing are not valid. We've had nothing but good experiences working with this client for the past two to three years. We wouldn't refer you them if we felt like you were going to be in danger and it was going to be impossible for you to do this work." In the end they did take the person, but it was not an easy transition. (ACT 15SP)

While some participants attributed stigma to perceptions of "difficultness" related to psychiatric treatment (e.g., refractory symptoms, lack of insight, non-adherence to medications), others felt stigma was associated with perceived dangerousness necessarily resulting from the embedding of police officers in ACT. Some service providers noted that having officers attached to their teams carried with it an assumption that "protection" and "use of force" were necessarily components of ACT treatment. Most of my participants experienced consumers referred from the ASP team in this setting as generally higher in criminogenic history and dangerousness (risk) compared to other referrals. The ACT service providers differentiated these "dangerous" consumers from other referrals and resisted their enrollment in ACT based on perceived risk. This

perception of dangerousness was almost always linked with the enhanced level of police support that ASP service providers had (one police officer per service provider) compared with that of ACT team service providers (one officer to support five ACT teams). The following participant explained their concern related to the transfer of consumers from ASP to ACT and called attention to the use of body armour by ASP service providers:

And some people on the team are like well, “you’re [i.e., the ASP service provider] seeing this guy with a cop, every time you see him, and you wear a bulletproof vest, and I am seeing him by myself the week later. What do I? What? Why? What’s the difference here? What’s . . . you know?” Because it’s the same guy, so why are you introducing him like this and I am seeing him like this? Is that safe? (ACT 1SP)

This service provider emphasized concern that I heard from a number of participants: the involvement of police officers in treatment becoming entangled with discourses of perceived dangerousness. Further, the differing intensity of police involvement from ASP to ACT and from ACT to other services was seen as a barrier to flow within the larger system of care. This was because the next service would question the safety of providing services to these consumers because they lacked the police protection afforded to the service providers making the referral.

I found that the care plans of some consumers required that engagement by healthcare clinicians only occur in the company of a police officer. Consistent with this, almost all participants experienced that because intake had privileged forensic or criminally involved consumers, embedded police officers were now a necessary component of daily treatment for these ACT teams and had to be continued to ensure the safety of service providers. However, participants also noted that although police-embedded ACT in this setting had expanded to five teams since 2012, police support had not increased proportionally and was usually limited to one officer on any given day to support five ACT teams. Because of this, service providers perceived a need to constantly triage and evaluate whether a police presence was required, and to arrange treatment for some “dangerous” consumers to fit the scheduling of these officers. Several participants shared experiences where clinical decisions were influenced by access to a police officer (e.g., rescheduling an injection attempt because an officer was

not available), or gave examples of feeling pressure to see clients without officer support, despite safety concerns. The following excerpt provides an example of staff feeling obligated to respond to a behavioural crisis, despite believing that the situation was dangerous and that it would be better if directed to police resources:

I often find too because our guys have that huge history of violence and a lot of them are still quite untreated, homeless, and continuing where they are. Because we have committed to meeting people where they are, we have other service providers now going “oh that person is an ACT person, let’s phone the social worker, the nurse, whatever, and get them to come down here and deal with this huge level of aggression and violence.” So, like “oh hi, it’s [name], this person is in our office, we’re all in lockdown, they’re absolutely ripping it apart and destroying it, can you come down here and talk to them?” And it’s like “that’s a call for police actually. Stop calling me, and go call the police,” but they want us to come down there and deal with it. And often we do, which is stupid. (ACT 14SP)

My findings supported that the embedding of police officers, and the blurring of roles in a multidisciplinary team, contributed to participants feeling obligated to respond to incidents of behavioural crisis that they believed were dangerous. Interestingly, none of the participants sharing stories of attending calls related to behavioural crisis such as those described above associated their interventions with “treatment.” Rather, they viewed these instances as requiring their attendance in order to maintain relationships with community partners by appearing to be responsive and attempting to defuse the situation.

Although only a small number of service providers spoke about actual acts of physical violence against staff, the majority shared that “near misses” and instances of verbal aggression were common. My observational fieldwork also provided pertinent data when ACT service providers were observed attempting to administer an injectable psychiatric medication to a consumer on the street while this individual directed verbal threats of violence towards them. A plainclothes ACT police officer stood within arm’s reach of this interaction and appeared to be attempting to verbally deescalate the situation.

In summation, I found a strong theme that consumers were stigmatized as inherently dangerous in this ACT model with embedded police officers. These perceptions of dangerousness were linked with the embedding of police officers within the ACT model as well as the privileging of referrals for consumers with violent histories in this setting. My findings suggested that collaboration between police and mental health treatment had system-level implications whereby services with lesser or no police officer involvement perceived enhanced exposure to risk when consumers were transferred to their care. Related to this, I found that discourses of dangerousness created barriers to flow and graduation, as less-intensive services pushed back against perceived risk and inadequate protection when engaging these consumers in treatment. I also elicited an important finding showing that in a multidisciplinary treatment model such as ACT, where service provider roles can overlap, the embedding of police officers created a perceived blurring between healthcare and policing.

6.3.4. Service Provider Attitudes

Consistent with previous qualitative research on ACT, I found that some service provider participants held personal beliefs that conflicted with the goal of ACT consumers successfully graduating to less-intensive services. Although this theme was derived from experiences of a minority of my participants, I assessed the impacts as farther reaching than might be expected, due to the team-based nature of ACT decision making and the consensus-based process used amongst ACT team members to determine whether an individual was ready for graduation. Because of this shared decision-making model and need for consensus, a single service provider could effectively block graduation for a large number of consumers. I also found that although only a minority of participants were philosophically opposed to ACT graduation, many more disagreed with how it was being implemented and questioned whether consumers would be successful, due to the gap between ACT-level services and those of the traditional mental health teams to which the consumers would graduate. I found that these concerns created barriers to the successful implementation of ACT graduation because service providers did not have faith in their current process or a belief that its implementation would benefit consumers.

A consistent theme among participants opposing ACT graduation was the belief that “appropriate” ACT consumers should necessarily have a level of complexity that

required long-term ACT intervention. For these service providers, consumers who reached the point of requiring ACT services should have previously exhausted primary and secondary treatment services.²⁴ Therefore, graduating ACT consumers back to such services should only be considered after a significant period of stability through ACT treatment, if ever. In other words, because ACT consumers had previously “failed” (or been failed by) those lower-intensity services, graduation carried with it an inherent risk of decompensation. The following participant explained their stance against graduation:

It’s totally pressure. I guess they would like to see that people have graduated from ACT. I don’t know if that is a thing that makes it look good on paper. I don’t think it is. I mean graduating; it doesn’t make any sense . . . that doesn’t make any sense. That’s always kind of bugged me. (ACT 17SP)

When this participant referred to “pressure,” they were pointing to system-level pressure for the police-embedded ACT teams to graduate consumers to make room for others. This participant, and most others I interviewed, questioned the use of graduation as a metric for treatment success. Service providers cautioned that this could create a positive feedback loop whereby pressure to intake new consumers contributed to pressure to graduate others, and the measurement of a process (flow in and out of ACT) would eclipse other meaningful outcomes, such as improved quality of life or symptom stability.

Linked with the previous point, almost all of my participants shared experiences that their respective ACT team had graduated consumers who quickly decompensated, resulting in a referral back to ACT. One participant explained:

It is a problem. . . . We’ve tried to discharge a few clients to mental health teams, [but they] bounced back to us very quickly. [The mental health team service providers would say]: “we couldn’t get them their meds,” “they said they didn’t want their injection,” “we weren’t able to follow up or we didn’t follow up.” So, they bounced the referral back to us and the next thing you know they are back on our caseload. (ACT 15SP)

²⁴ ACT is considered a tertiary resource in BC and is therefore usually only accessible after both primary and secondary resources have been exhausted. Primary services include general practitioners and community resources. Secondary services include hospitals and specialist services.

This participant later specified that their team had expressed concerns that this consumer might not be ready for graduation, but there had been pressure to complete this process in order to facilitate the enrollment of other consumers who were waiting for ACT. The participant also noted that the time between graduation and referral back to ACT was less than six weeks. These experiences of consumers being re-referred to ACT within a short time after graduation were perceived by most participants as a general failing of the larger treatment system and an indication of the gap between the level of service that ACT could provide and the service delivered by the next level of intensity, a mental health team. The following excerpt provides an example:

There is a big jump. There is a huge gap, but the fact that there is nothing in between, the ACT team has all the pressure to continue looking after these people and taking people, and keeping people, while there is nothing in between. (ACT 20SP)

This participant's perception is important because it speaks to the systemic pressure to continue taking new consumers into ACT even if outflow was impeded. Although general orientations against ACT graduation came from only a few of my participants, a larger number of service providers perceived that a core group of ACT consumers would never be able to graduate successfully. The following participant succinctly summed up this point:

I do know the system, and I hear it all the time, that we need to move people along the continuum and provide supports so that they can start to function better and then they will need less support, and that drives me fucking crazy. . . . Because some people are just not going to function well on their own. They're always going to need support. I think it's so unrealistic to think, especially a lot of our clients who have extensive trauma histories, they're street entrenched, The Block is their community. So, to expect that they are somehow going to magically start functioning better and move out of The Block and need less supports, it's a pipedream. It's so unrealistic. That may sound pessimistic. It's not very recovery focused, which is that sort of hopefulness that people can recover. But I guess it's "how do you define recovery?" People, I think, can recover, but they might need a lot of support, forever. (ACT 18SP)

This participant also raised the question of whether there remained a need for a long-term institutional setting for a small cohort of ACT consumers who continued to experience severe marginalization and poor functioning in community settings, despite ACT treatment. A minority of my participants advocated lifelong institutional options for some ACT consumers.

In contrast to those who questioned the appropriateness of ACT graduation, a larger group of participants viewed “paternalism” among some of their colleagues as the greatest barrier to successful ACT graduations. The following excerpt provides an example:

They [i.e., ACT consumers] don’t want to stay with us forever. This is something that makes me nuts. . . . Clinicians . . . who say “we’ll make them dependent; they’ll never leave us.” Crap! Nobody wants to stay with us! I think it’s peoples’ own stuff [that is a barrier to graduation]. It’s peoples’ fear of not being skilled enough to disengage, because otherwise it’s a bunch of garbage. People want to graduate; people want to get better. Yeah, to me it’s countertransference.²⁵ It’s the clinicians’ own concern about being dependent on something. (ACT 7SP)

This participant challenged concerns raised by some other participants—that ACT enrollment, and the intensive wraparound service delivery it provided, necessarily created dependency. In other words, some participants expressed that even if ACT enrollment was associated with improvement in symptoms, functioning, and stability, this was necessarily linked with ACT services themselves and likely could not be maintained if a consumer were graduated to a less-intensive treatment option. This perception that ACT created dependency was strongly held by some of my participants and was their justification for doubting or rejecting the potential of graduating ACT consumers.

While only a small number of my participants were philosophically opposed to ACT graduation, there was a strong belief that graduation practices occurred prior to consumers reaching a point of optimal stability and recovery. Almost all participants shared experiences of graduations that felt “rushed” and cases where there was perceived pressure to graduate consumers, even when service providers believed that

²⁵ When this participant uses the term countertransference, they are referring to the impact on a consumer of the unconscious feelings of a service provider. The term countertransference comes from the work of the founder of psychoanalysis, Sigmund Freud.

more time in ACT would result in further improvements or increased stability of treatment gains. In other words, system-level pressure for ACT to intake new consumers impacted decisions to graduate the “most ready” consumers, despite apprehensions that this would result in decompensation. Service providers shared that in order to maintain manageable workloads, graduating the “most ready” consumers to other services was the best option to make room for others.

In summation, I found that service provider attitudes could impact the implementation of ACT graduation processes. My findings showed that opposition to ACT graduation could range from outright philosophical rejection, to questions of its efficacy, to beliefs that ACT treatment resulted in dependency. My findings called attention to the impact that these opinions could have within the context of team-based service delivery and decision making within the ACT model.

6.4. Discussion

I have presented my findings under the themes of intakes and politics, graduating “poor-fit” consumers, the stigma of dangerousness, and service provider attitudes. Although I have presented these as distinct themes, they are inherently interrelated. My results illuminated the heterogeneity of consumers enrolled in this police-embedded ACT model, and the potential for differing consumer profiles to shape their treatment outcomes and their graduation to less-intensive services. Although I attempted to elicit both facilitators and barriers to graduation, my findings predominantly identified the latter.

6.4.1. Fit with Previous Literature

My findings highlighted facilitators and barriers to graduation from a grouping of ACT teams in a municipality in BC, Canada that are distinctive because since inception, they have incorporated embedded police officers and integrated graduation processes. My results are organized through a novel systems-level analysis of flow that positions ACT as part of a continuum of services within a larger treatment system. To my knowledge, my research is unique because of this in-depth systems analysis of graduation and flow that draws upon data from both interviews and observational fieldwork. I believe this has facilitated a more robust understanding of intake and

graduation while providing insights into how ACT teams can increase their accessibility and utility to the larger system in which they are nested. My findings show that service providers experienced flow towards ACT (enrollment) as inextricably linked with flow out (graduation) and vice versa. Previous research has predominantly compartmentalized flow through focus on graduation processes alone (see Bromley et al., 2017; Donahue et al., 2012; Finnerty et al., 2015; Hackman & Stowell, 2009). My findings underscored that ACT teams incorporating graduation practices and processes should be viewed as systems seeking homeostasis, and that the concept of ACT graduation should necessarily incorporate analysis of intake and enrollment, and the larger treatment systems they operate within. I therefore recommend that other researchers follow my lead in future investigations of this topic.

My findings also suggested that the unique partnership between policing and mental health treatment has resulted in the enrollment of a high number of criminally or forensically involved consumers. While the BC ACT standards speak directly to an expectation that ACT teams should enroll consumers with criminal justice system involvement, they specify that this should occur when that criminal involvement is related to mental illness, and when the consumer poses low to moderate risk in the community (BC Ministry of Health Services, 2008). These standards also assert that as part of enrollment screening, ACT should assess the level of risk these consumers pose and whether ACT “is able to manage the current level of risk in the community” (BC Ministry of Health Services, 2008, p. 5). My findings showed that service providers within police-embedded ACT perceived a privileging of criminally involved consumers for ACT enrollment, and felt their teams were unable to push back against these referrals, despite concerns about risk.

Previous research has identified that ACT consumers face considerable stigma as a by-product of intersecting aspects of their identities, such as poverty, homelessness, mental illness, substance use, unemployment, and criminal justice system involvement (Finnerty et al., 2015; Krupa et al., 2005; Prince & Prince, 2002; Smith et al., 2013; Ye et al., 2016). Further, there is evidence that stigma can specifically result from identification as an ACT consumer (Angell, 2003; Krupa et al., 2005). On the other hand, some research has also shown that ACT (without police officers) has the potential to reduce stigma for consumers through interventions that enhance community integration (Ye et al., 2016), and by increasing other community providers’

understanding of biases that contribute to ACT clients being overrepresented in the criminal justice system (Scheyett et al., 2010). My findings make key contributions in this area by emphasizing how stigma can be exacerbated by the embedding of police officers within the ACT model, due to perceptions that the embedded officers are necessary to mitigate risks associated with ACT consumers. My findings are also important because they illuminate a perceived emphasis on criminogenic profiles for consumers being enrolled in this police-embedded ACT model. These findings should be considered within the context of the police advocacy that led to the emergence and rapid expansion of the police-embedded ACT model in BC (Thompson, 2010; Wiebe, 2016; Wilson-Bates, 2008). Previous research has stressed that this police advocacy and the declaration of a mental health crisis accentuated narratives of violence and risk associated with the twinning of mental health and substance use issues in this setting (Boyd et al., 2015; Boyd & Kerr, 2015). Given that this advocacy contributed to the genesis of the police-embedded ACT model in BC, the discourses of dangerousness emphasized in my findings may be a foreseeable outcome. My findings that treatment contacts for some ACT consumers necessarily involve the presence of police officers parallels an issue emphasized in a report commissioned by the police department in Victoria, Canada, where examples of the police-embedded ACT model have emerged. That report presented findings indicating that some Victoria ACT service providers view continued police involvement as a necessity, given the risk profiles of enrolled consumers (Costigan & Woodin, 2018). My findings have similarities, raising caution that systems creating police-embedded ACT teams may face barriers should there be a decision to extricate police from the model and revert to the standard ACT model at some point.

Previous research has cautioned that the profiles of consumers enrolled in ACT (diagnosis, social needs, hospital utilization) are of the same importance as structural aspects of service delivery in producing positive outcomes (Salyer & Bond, 2009). In other words, the right consumers must be enrolled in ACT for it to produce positive results that justify its expense. Although previous researchers have identified a trend towards heterogeneity of ACT consumer profiles, there is also recognition that this necessarily increases the complexity of providing services and introduces a need for more individualized planning by service providers to ensure successful graduations (Chen & Herman, 2012). My findings build on research showing that ACT can be

perceived as a “catch-all” or “silver bullet” for consumers who do not fit into other parts of larger treatment systems. For example, Chen and Herman (2012) identified service provider concerns that consumers with primary issues such as developmental disabilities and dementia are being enrolled in ACT programs prior to exhausting secondary community treatment resources. Those researchers cautioned that deficiencies in other parts of these larger treatment systems can contribute to ACT being used as a “first stop” when no adequate services exist (Chen & Herman, 2012). My findings align with this previous research and provide further caution that using ACT as a “silver bullet” intervention enhances the potential for it to become a blend of secondary and tertiary services, without addressing system gaps that pose likely barriers to eventual graduation.

My findings also provide caution against enrolling consumers with borderline personality disorder (BPD) within ACT and point to potential countertherapeutic effects directly resulting from the team-based nature of ACT service delivery. Horvitz-Lennon and colleagues (2009) cautioned that despite an emerging trend of ACT enrollment for consumers with BPD, this is being done without evidence to support treatment efficacy with this population. The limited research on this topic cautions that ACT alone is likely ineffective in treating BPD and that evidence-based interventions with proven efficacy, such as dialectical behavioural therapy, should be incorporated within the ACT model to increase the potential for positive outcomes should this population be enrolled (Burroughs & Somerville, 2013; Horvitz-Lennon et al., 2009).

In addition to findings showing that the profiles of ACT consumers can create barriers to graduation, my work also builds on previous research showing that service provider attitudes can pose barriers to implementing ACT graduation (Bromley et al., 2015; Cuddeback et al., 2013). My findings provide more descriptive detail than previous research that has identified how service provider resistance to ACT graduation can stem from concerns that graduated consumers will decompensate without ACT, that consumers will fall through treatment gaps post-graduation, and that consumers become dependent on ACT care (Bromley et al., 2015; Chen & Herman, 2012; Cuddeback et al., 2013; Finnerty et al., 2015). My findings are also consistent with previous research that has identified the transitional period immediately after ACT graduation as a particularly vulnerable time for consumers (Bromley et al., 2015; Chen & Herman, 2012; Watts & Preibe, 2002). I note that some jurisdictions have sought to address this vulnerable

period through a recent adaptation to the ACT model known as Flexible ACT (FACT), which incorporates a less-intensive case management model within a standard ACT team, facilitating step-down case management (Firm et al., 2018; Lexén & Svensson, 2016; Svensson et al., 2017). The FACT model creates capacity for the rapid transfer back to ACT-level services of consumers receiving standard case management, as well as communication and treatment continuity during these transitions. The addition of internal case management services within the FACT model also facilitates higher caseloads than traditional ACT teams while maintaining a 1:10 staffing ratio for those consumers requiring ACT-level services. Recent research has shown that FACT provides consumers with the opportunity to transition between different levels of treatment intensity without actual graduation from ACT to a separate program (Firm et al., 2018; Svensson et al., 2017). My findings suggest that the FACT model may be well suited to the BC context and that the step-down treatment it provides internally may alleviate concerns raised by my service provider participants. Notably, other Canadian provinces are already investing in the FACT model as an alternative to standard ACT (Government of New Brunswick, 2018). Given the barriers to graduation my research has identified, policy makers may wish to consider the implementation of FACT, accompanied by research and evaluation to determine its efficacy in other Canadian jurisdictions.

6.4.2. Strengths and Limitations

There are limitations to my research. Firstly, my interview data come solely from ACT service providers. Although this study was part of a larger research project that included interviews with consumers, I was unable to acquire robust data from my consumer sample related to flow and graduation. I attribute this, in part, to my inability to recruit consumers who had graduated from ACT. I also note that my findings revealed consumers appear to be largely uninvolved in the decision-making process of becoming enrolled in or graduating from ACT services. A scan of the available qualitative literature on this topic reveals that the majority of authors have also focused on the perceptions of service providers. I view this as a limitation of my own work and the larger body of research as a whole. I concur with Hackman and Stowell (2009), who noted that future research should target consumers' perspectives on graduation practices to develop a more well-rounded understanding of graduation processes.

Secondly, my sample was deliberately recruited from five police-embedded ACT teams located in one Canadian city and therefore may not be directly transferable to other jurisdictions. Although I note this as a limitation, I feel that I have provided sufficient contextual detail and data-near results to allow readers to consider my findings in relation to other settings.

Despite these limitations, my findings are rich and provide detailed insights into the complexities experienced by ACT service providers working within a system requiring flow both into and out of ACT. Through developing a better understanding of these experiences, my findings call attention to both facilitators and barriers to flow associated with the ACT model and the larger continuum of care for severe mental illness. My results are important because they incorporate a systems-level analysis of ACT graduation that has been largely absent from previous research. My findings are also important because they highlight how competing stakeholder priorities within an ACT model can shape consumer profiles and the feasibility of eventual graduation from ACT as well as flow within the larger treatment systems within which ACT teams operate.

6.4.3. Conclusions

ACT graduation and enrollment processes are inextricably linked and best understood through a systems analysis. Pressure for flow through graduation or enrollment has ramifications for the entire system. Unclear criteria for enrollment and discharge can create uncertainty for service providers and contribute to perceptions that the wrong consumer profiles are being emphasized. Multiple stakeholder collaborations (such as police and mental health services) within an ACT model can create competing service delivery priorities that influence the profiles of enrolled consumers and potentially create barriers to graduation processes. The embedding of police officers in ACT can increase the complexity and heterogeneity of consumer profiles within this treatment model and enhance a stigmatizing narrative of dangerousness associated with ACT consumers. Although the ACT model is robust enough to be perceived as a catch-all or “silver bullet” intervention, if the wrong consumer profiles are emphasized in enrollment criteria, this can negatively shape treatment delivery experiences for service providers and create barriers to eventual graduation. Such barriers contribute to treatment stagnation and/or a necessity to graduate consumers irrespective of the suitability of

available discharge resources. Future research should focus on the perspectives of consumers to address knowledge gaps and facilitate a more well-rounded understanding of graduation processes and practices.

Chapter 7. Conclusions

7.1. Introduction

In this dissertation, I have undertaken an extensive qualitative investigation of a unique variation of ACT that has been modified through the addition of embedded police officers. My findings build on previous research, make unique contributions to the literature, and point to areas for future inquiry. These findings have implications for clinicians, administrators, researchers, and policy makers. In this final chapter, I discuss overarching study limitations, review some of the larger implications of my research, propose areas for future research, and provide a brief conclusion.

7.2. Limitations of My Research

I have already detailed potential limitations of this research in the three standalone manuscripts where my major findings are presented. In addition to these, there are three overarching limitations that relate to the larger research project.

Firstly, it should be recognized that this research was conducted with the timelines, financial constraints, and structural limitations inherent to a dissertation project. The study design, ethics approval, data collection, and analysis process were coordinated by a single graduate student, and this necessarily created limitations such as the amount of time that could be invested in each phase. An increased number of interviews, or more hours of observational fieldwork, could have bolstered the breadth of data to draw upon if there had been a longer timeline for this study or if more researchers had been involved. More time devoted to analysis could also have increased the degree of self-reflection possible and may have impacted analysis. However, it is noteworthy that the sample size attained was larger than most of the qualitative ACT research studies reviewed, and data saturation was reached on major themes. Also, the collection of data from three sources and the ability to link these together exceeded most previous qualitative ACT research.

Secondly, this research would have benefited from consumer participation or input with respect to study design, data collection, and analysis. Although I involved two

ACT consumers in the analysis portion of this research, I did so primarily as a form of member checking and to facilitate data triangulation. This proved to be a valuable process and highlighted that enhanced consumer participation or participatory action research would likely have produced interesting and valuable results. I also note that the literature shows increased interest in mental health consumer involvement in research projects that focus upon or impact their care (Schneider, 2012). Although I acknowledge this as a limitation of my research, I cannot find a single example of a consumer-driven ACT research paper in the peer-reviewed literature. This is a limitation that should be addressed by future researchers.

The third overarching limitation of my research pertains to the methodology employed and my adherence to its requirements. In this project, I have been careful to claim only that my research is informed by, or draws from, grounded theory ethnography, rather than asserting that it *is* grounded theory ethnography. A primary reason for making this distinction is that I was unable to reach a point of confident theory generation. Although I believe that my results present a descriptive account of the phenomenon of study, I do not feel they have generated an overarching theory that satisfies the requirements of grounded theory ethnography. While I note this as a limitation of my own work, some researchers have argued that pure methodological adherence is a common issue in most qualitative research (Sandelowski, 2000, 2010).

7.3. Key Contributions

My research presents findings that offer important contributions to the ACT literature as well as the larger body of research on the treatment of severe mental illness and concurrent disorders. While these findings have been described in previous chapters of this dissertation, I will present two important themes evident across these chapters for further discussion here: the importance of relationships and the impacts of stigma.

7.3.1. Relationships

The importance of relationships was an underlying theme that permeated my results and was emphasized in all three of my findings chapters. My findings showed that relationships between ACT consumers and service providers, and between

consumers and ACT peer support specialists, as well as social relationships amongst ACT consumers, and relationships between ACT service providers and individuals in outside agencies such as housing workers and landlords shaped multiple experiences of ACT service delivery and outcomes.

Previous research has emphasized that ACT consumers can often be characterized by disconnection from their families, social networks, treatment providers, and society in general (Finnerty et al., 2015; Gomory, 1998; Krupa et al., 2005; Prince & Prince, 2002). Indeed, a component of the functional disability identified as a characteristic of ACT consumers comes from their disconnection from others and loss of family and societal role functioning (Prince & Prince, 2002). My findings build on that previous research but move further in identifying that previous traumatic experiences enhance social disconnection. My results showed that such trauma could be a product of previous physical or sexual abuse, prior episodes of forced treatment, the emergence of mental illness, and periods of homelessness. My findings indicate that while these traumatic events themselves may not be preventable, they do offer focal points for early intervention that could reduce or prevent their debilitating impacts on the lives of consumers. My research points to the potential power of such early intervention strategies and a need for further research examining their implementation. Future research should consider consumer experiences associated with the implementation of early interventions as well as how they may alter life and treatment trajectories for consumers. Examining the perspectives of consumers' family members could also reveal how early intervention strategies strengthen and maintain social relationships and family bonds that could otherwise be disrupted by mental illness.

Previous research has examined the impact of ACT service delivery on increasing social and therapeutic connections for ACT consumers and has described the treatment benefits of doing so (Angell, 2003; Appelbaum & LeMelle, 2008; Bromley et al., 2013). My findings make key contributions in this area through identifying the proliferation of a transitional supported housing model in my research setting and how it can impair the formation of social relationships for consumers. My findings showed that the time-limited nature of transitional housing impairs the desire and ability of ACT consumers to form relationships in their housing setting and surrounding neighbourhoods. Thus, the time-limiting policies designed to promote flow within the supported housing system are necessarily impairing an important aspect of ACT

treatment by perpetuating social disconnection. This finding is important because of its implications for policy makers and administrators designing housing options that can optimize recovery for ACT consumers by maximizing the potential for social connections. This finding also speaks to a need for future research examining consumers' experiences related to housing and social connections.

Another important aspect of relationships identified in my research is the bond between ACT consumers and their service providers. This topic has been explored by previous researchers, especially with respect to how such relationships can build trust, improve treatment engagement, and increase overall satisfaction with ACT treatment (Angell, 2003; Estroff, 1981). Building on that research, more recent qualitative studies have shown that the therapeutic relationship between consumer and service provider has the potential to mitigate perceptions of coercion associated with ACT treatment (Cuddeback et al., 2011; Krupa et al., 2005; Leiphart & Barnes, 2005; Pettersen et al., 2014; Thøgersen et al., 2010). My findings were consistent with previous research showing that factors such as feeling listened to, understood, and validated contribute to positive therapeutic relationships and reduce negative experiences associated with other interventions, such as the administration or monitoring of medications (Leiphart & Barnes, 2005; Micoli, 2009; Thøgersen et al., 2010; Watts & Preibe, 2002). These relationship-based interventions are referred to in the qualitative literature as attributes that contribute to overall high levels of satisfaction with ACT service delivery (Cuddeback et al., 2011; Lamberti et al., 2014; Leiphart & Barnes, 2005; Pettersen et al., 2014). My research builds on those findings but also makes unique contributions by identifying the role of ACT peer support specialists in building a therapeutic relationship with consumers that can establish trust extending beyond themselves to other service providers and ACT treatment in general. Although I was able to find previous studies that have pointed out the importance of peer support within the ACT model, my research is unique in its linkage of a trusting relationship between peer support and consumers with decreased perceptions of coercion from ACT treatment.

My research also found that relationships between ACT service providers and outside agencies are important in shaping overall treatment experiences within the ACT model. While previous ACT research has examined the therapeutic relationships between consumers and service providers, it is rare to find mention of other relationships associated with ACT service delivery. My research therefore makes important

contributions by identifying the importance of relationships between ACT service providers and outside agencies, and by examining how these relationships shape treatment experiences for consumers. For example, my findings showed that ACT service providers experienced close relationships with housing providers as important aspects of service delivery because of the enhanced reciprocal information sharing it facilitated. However, while service providers saw these relationships as helpful, consumers viewed them negatively and as synonymous with enhanced surveillance and monitoring. My findings also identified how the contextual environment of a housing crisis in this urban setting has led service providers to privilege relationships with landlords over facilitating housing for some of their more complex consumers. This finding is important within the context of previous research and my own findings highlighting the negative impacts of homelessness and housing instability on ACT consumers and ACT service delivery. Negative impacts identified by my research include the creation of barriers to the formation and maintenance of a therapeutic bond between service providers and consumers.

7.3.2. Stigma

A second important theme within my research is stigma. Previous research has identified that societal misconceptions and stereotypes pertaining to psychiatric diagnosis contribute to stigmatizing narratives about mental illness itself and mental health consumers (Gonzales et al., 2014; Prince & Prince, 2002; Smith et al., 2013; Ye et al., 2016). Previous research has also identified that stigma faced by ACT consumers is not limited to their mental illnesses. Rather, it is a by-product of intersecting negative discourses associated with poverty, homelessness, substance use, mental illness, unemployment, criminal justice system involvement, and even enrollment in ACT services themselves (Angell, 2003; Finnerty et al., 2015; Krupa et al., 2005; Prince & Prince, 2002; Smith et al., 2013; Ye et al., 2016).

My findings provide unique contributions by highlighting how stigma faced by consumers may be exacerbated by the embedding of police officers in the ACT model. My results showed that this collaboration between policing and treatment appears to enhance discourses of dangerousness—namely, that officers are necessary to mitigate risks that ACT consumers pose during the provision of treatment services. This finding is important, especially within the context of the actual operational capacity of these teams,

which limits the ability of that officer to attend more than a small proportion of service delivery episodes. Despite these operational restrictions, the collaboration between policing and treatment nonetheless fosters stigmatizing discourses of dangerousness associated with police-embedded ACT consumers.

My results also contribute to the literature on “territorial stigma,” and to my knowledge, this is the first study to link this philosophical concept with ACT service delivery. As described earlier in this dissertation, Wacquant (2009) used territorial stigma to describe a process whereby residency in marginalized geographic spaces (often described as “slums” or “ghettos”) results in the transfer of stigma associated with those spaces upon residents. He described how territorial stigma marks residents of these marginalized neighbourhoods in a manner similar to a physical blemish, justifying stigmatizing treatment both within that space and when these residents travel into more affluent neighbourhoods (Collins et al., 2016; McNeil et al., 2015; Wacquant, 2009). Although previous qualitative ACT literature has produced descriptions highlighting the financial hardship and associated stigma faced by ACT consumers (Cuddeback et al., 2011; Estroff, 1981; Krupa et al., 2005), there is an absence of analysis related to the environmental context that it produces, such as the constriction of housing options to marginalized neighbourhoods.

My findings are important because they identify and link the financial marginalization and stigma experienced by ACT consumers with purposeful policy decisions and government regulations. Almost all of my consumer participants were financially supported through income security programs for people with disabilities. Therefore, the poverty precipitated by these rates and their mismatch with the actual cost of living is necessarily condoned by government and society at large. My findings emphasize that the “shelter” portion of income security measures (CAD 375) designated for housing costs falls far short of most options in my research setting and influences the geographic funneling of ACT consumers into The Block neighbourhood, where there is a clustering of lower-cost housing options and temporary emergency shelters. My research points to the impacts of these inferior housing options and homelessness, which create barriers to mental wellness and ACT service delivery. The observational fieldwork that I conducted facilitated a better understanding of the geographic space of The Block neighbourhood, where the majority of my ACT consumer participants resided, and how it builds upon other sources of stigma, such as mental illness diagnosis.

Researchers from other fields have used territorial stigma as an organizing framework in their analysis of how The Block has become an epicentre of marginalization, and how discourses vilifying this space through stigma associated with open drug use, mental illness, dangerousness, and delinquency transfer to residents (Collins et al., 2016; McNeil et al., 2015). Through the concept of territorial stigma, my research has introduced a theoretical lens to the ACT literature that provides an organizing structure to better understand the intersecting aspects of stigma faced by ACT consumers.

7.4. Conclusions

My findings diverge from previous qualitative research through strong themes of coercion related to ACT treatment. My results reveal that experiences of coercion are linked to structural elements of the ACT model, the provisions of Extended Leave, and the embedding of police officers within these ACT teams. My findings call for caution in the use and expansion of this police-embedded ACT model due to concerns that this modification contributes to coercive experiences for both service providers and consumers. My findings also speak to the need for independent investigation and oversight of the use of Extended Leave provisions in British Columbia to increase procedural safeguards and to prevent this legislation from being perceived as a mechanism of social control.

Inadequate housing and homelessness create barriers to ACT service delivery and are sources of trauma for consumers. System-level prioritization of ACT consumers is necessary to counteract current barriers that exclude them from accessing permanent supported housing in this setting. Early intervention strategies should be prioritized to prevent the functional impairments, disability, and housing instability that eventually contribute to the need for ACT enrollment.

ACT graduation and enrollment processes are inextricably linked and best understood through analysis acknowledging that pressure for flow through enrollment or graduation has ramifications for the entire system. Unclear enrollment and discharge criteria can create uncertainty and contribute to perceptions that the wrong consumer profiles are being enrolled in ACT services. Multiple stakeholder collaborations in ACT create competing priorities that influence the profiles of enrolled consumers and can create barriers to graduation. The addition of embedded police officers in ACT can

increase the complex heterogeneity of enrolled consumers, enhance the stigmatizing narrative of dangerousness, and create barriers to eventual graduation. Barriers to graduation result in treatment stagnation or a need to graduate consumers irrespective of readiness.

The ACT model originated over 40 years ago, and its longevity can be attributed to its strong outcomes but also its flexibility in adapting to changing healthcare system needs. My research begins the process of describing and analyzing an ACT model with embedded police officers that has emerged within a healthcare context in which police have identified treatment gaps and a need for collaboration. Although my research has identified benefits of this police-embedded ACT model, it has also illuminated concerns that speak to the need for future research to further investigate this phenomenon and test the themes I have presented.

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