Assertive Community Treatment: Field Practicum Report

A MSW Field Practicum Report
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By:
Chanda McFadden
Regina, Saskatchewan
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Abstract

The following report is an account of my practicum experience at Calgary Assertive Community Treatment program. This report offers personal experiences and reflection, as well as a review of current literature concerning the complexities associated with severe mental illness. Mental health service delivery through this model is discussed throughout the course of the report, outlining both advantages and criticisms of the model.

The Assertive Community Treatment Model, together with its vital components and guiding principles, is considered a successful course of action for treatment of individuals experiencing severe and persistent mental illness. This service delivery model aids in accomplishing several evidence based advances including but not limited to decreased symptoms of mental illness and overall positive gains for individual recovery. The social work profession, in particular, shares an important contribution towards the success and effectiveness of this treatment model.
Acknowledgments

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Chapter 1: Introduction

This practicum report is structured with the following headings: introduction, values and philosophies, theoretical frameworks for practice, mental illness, practice models of service delivery, assertive community treatment strategies, ethical practice in mental health service delivery and conclusion.

Chapter one of this report will include a detailed practicum report outline and a discussion regarding the rationale for my decision to complete my practicum at Calgary Assertive Community Treatment Program. In this chapter, I will also outline my practicum objectives, learning activities and skills that were established during my practicum experience.

1.1 Practicum Report Outline

The report reflects my experiences as a master’s level-practicum student at Assertive Community Treatment (ACT), in Calgary Alberta. I will discuss several objectives and learning activities that were completed during my practicum experience. Both the recovery oriented model and the ACT model will be incorporated throughout this report, as well as my personal contributions in implementing these frameworks as a practicum student. Through personal reflection and analysis, this report will highlight personal accounts and experiences of working with the mental health population. Current and relevant literature relating to severe mental illness, stigmas and challenges experienced by people suffering with mental illness as well as the effectiveness of assertive community treatment as a model for mental health will also be included throughout this report. Furthermore, the role of social work in mental health service delivery will be discussed. It is also important to note that throughout the report, identifying information has been changed to protect the identities of the clients.
1.2 Rationale for the Practicum

I had the opportunity to complete my field practicum at Assertive Community Treatment an Alberta Health Services program located in Calgary that provides support to individuals affected with severe and persistent mental illness. I successfully completed the practicum on a full-time basis, commencing on May 24th, 2016 and ending on August 10th, 2016.

In choosing my placement, my goal was to have a challenging educational experience. I was interested in exploring the area of mental health, as my professional experience in the field of mental health was limited. Through my experience as a medical social worker and a casual crisis worker, I recognized that broadening my knowledge specifically in mental health would be a valuable opportunity for professional growth. Not only would this opportunity strengthen my skills as a current social worker, but it would also benefit and strengthen my future social work practice.

Since the completion of my bachelor’s degree in social work, I have been fortunate enough to receive guidance and mentorship from a variety of exceptional professors and colleagues within the community of Regina. While I have developed a sense of confidence and contentment in my existing practice as a social worker, I felt enthused to advance from my comfort zone, network with new people and become involved in an unacquainted professional experience. After much thought, as well as support and encouragement from my academic advisor, I chose to relocate to Calgary, Alberta. I completed my practicum in the complex, yet notable area of mental health service delivery, through Calgary’s ACT program.

1.3 Practicum Objectives and Learning Activities/Skills

Prior to beginning my MSW practicum, I established several objectives that I aimed to achieve over the course of the practicum. To complete these objectives, I identified several
learning activities to meet the objectives that I had outlined. In establishing my plan for the practicum, I chose to focus on more general and broad objectives, given my minimal clinical experience in mental health. I also chose to focus on more broad objectives, because I was not familiar with the city of Calgary as well as the community resources offered in this region. Detailed below are the five main objectives and the associated learning activities that I proposed to achieve during my practicum.

1. **Becoming familiar with regional mental health and community resources.**

   Having an adequate understanding and general familiarity of community resources is an important expectation and most often, a strength encompassed by the social work discipline. Since I had relocated to Calgary solely for this practicum experience, I felt somewhat unprepared in terms of my awareness and knowledge of regional mental health and community resources in Calgary. Fortunately, my practicum supervisor was flexible and accommodating, and I felt completely supported in striving to achieve this objective.

   I became familiar with regional mental health and community resources by attending several programs, including self-help drop in centers and supportive living and housing transition programs. I also achieved this objective by shadowing several mental health professionals, aside from only those at the ACT agency. I was provided the opportunity to shadow inpatient medical social workers, registered nurses and assessor coordinators. In addition, I also shadowed a mental health clinician employed in adolescent mental health, to develop a greater understanding and awareness of other mental health programs and services offered by Alberta Health Services.

   These diverse experiences helped provide me with the competency and knowledge of existing programs and services to support my clients as needed. With a basic understanding of the mental health supports and agencies within the city, I could refer clients to the appropriate
resources in the areas of financial services, homelessness, emergency services, housing services and additional wellness programs.

2. *To gain professional social work experience, knowledge, abilities and clinical skills to provide competent social work practice within the area of mental health.*

To achieve this objective, I began the practicum by intensively shadowing the ACT social worker who had a demanding workload. Through approximately two weeks of observations, I began to develop an improved understanding of the social work role, specifically within the assertive community treatment program. After developing this social work foundation, I also had the opportunity to further develop my skills by observing several other professionals in disciplines including psychiatry, nursing, recreational therapy, and occupational therapy. I went on to gain professional experience through direct practice by working independently with clients towards their individual treatment goals.

3. *To develop a greater understanding of current mental health legislation and community treatment orders (CTOs).*

I began working towards this objective by researching different types of literature, specifically, *The Guide to the Alberta Mental Health Act and Community Treatment Legislation.* My understanding of community treatment orders continued to develop throughout my practicum by working directly with ACT clients who were mandated by a CTO. I had involvement with several assertive community treatment clients regarding their personal experiences with community treatment orders, both positive and negative, and participated in CTO panel reviews and renewals. Furthermore, on three separate occasions, I shadowed a community treatment coordinator whose primary responsibilities included supporting and guiding hospital staff through admission and discharge paperwork relating to community treatment orders and
coordinating and facilitating discharge meeting for clients transitioning to community care under the mandate of a CTO.

The mentorship and guidance I received from the community treatment coordinator aided me in developing a sound knowledge of the Mental Health Act and the CTO legislation. Observing the process from hospital through to the community sector assisted me in clearly understanding the process, from start to finish. In working alongside clients subjected to community treatment orders, I also understood the importance of the legislation, as I had developed relationships with these individuals and learned that without community treatment orders, the safety of many of these individuals could likely be compromised. In my view, the most rewarding experience was to attend panel reviews and observe how CTO legislation has helped to support and impact clients in a positive way during their mental health recovery journey. Through literature, research, direct experiences with community treatment order participants and community treatment order coordinators, I have developed an improved understanding regarding the complexities in the process of community treatment orders and an overall improved understanding of the Mental Health Act and community treatment order legislation.

4. Developing clinical skills necessary to conduct psychiatry and psychosocial assessments, treatment plans and crisis intervention.

During my practicum, I demonstrated competence in this area by completing treatment plans with clients, reassessing treatment goals, and providing support and counsel to clients independently. I was expected to complete case documentation in accordance with Alberta Health Region documentation standards. Throughout the practicum, I also participated in psychiatry clinics, completed clinical assessments and participated in weekly clinical meetings.
with the assertive community treatment trans-disciplinary team. Furthermore, I observed six sessions of the Cognitive Behavioral Social Skills Training (CBSST) and implemented cognitive behavioral therapy strategies within my practice. I also attended a Dialectical Behavioral Therapy training session to increase my competency within this area of therapy, which I found specifically useful in working with clients diagnosed with borderline personality disorder or those with self-harming tendencies.

5. To develop a working knowledge of the ACT model.

Prior to this practicum experience, I was completely unaware of the ACT model. I became familiar with the principles of assertive community treatment through literature and research, ongoing observations and consultation with ACT team members, learning and participating in client triage and the intake process, as well as through practical and direct experience participating in ACT programming. Most importantly, I developed a working knowledge of ACT by focusing on the most primary principle of assertive community treatment, which requires the development of close working relationships with the clients and community resources.
Chapter 2: Values and Philosophies

The following chapter discusses the treatment values and ideologies incorporated within the ACT model. This chapter also focuses on the values and principles of the social work profession, highlighting the congruence and similarities between the ACT model and the philosophies of social work practice.

2.1 Assertive Community Treatment Values and Ideologies

Every organization emphasizes a specific set of values, distinguishing it from others. The AHS Ethics Framework (2014) states, “our values describe ways in which we can personally demonstrate our commitment to clients care in our daily interactions with individuals, their families and our colleagues. AHS staff, physicians and volunteers are expected to use the values to lead our work, our actions and decisions” (p. 4). The core values discussed by the AHS Ethics Framework (2014) include compassion, accountability, respect, excellence and safety; these values also support what the assertive community treatment program collectively stands for.

Research suggests that people tend to choose workplaces that enable them to express and reaffirm their personal value preferences (Tartakovsky, Gaitor-Shor & Perelman-Hayim, 2013). I was fortunate enough to experience this during my practicum, as many of the underlying ACT principles and beliefs were consistent with both my personal and professional values as a social worker. As will be discussed, several of the values incorporated in the ACT model are also in accordance with the Canadian Association of Social Workers (CASW) Code of Ethics (2005). The underlying principles and values of assertive community treatment are also congruent with the recovery model (Salyers & Tsemberis, 2007) which is discussed later in this report. Furthermore, the philosophies and ideals from strengths-based practice, as well as anti-
oppressive practice which form the theoretical underpinnings of this report are also incorporated in the guiding philosophies of ACT (Phillips & Burns, 2003).

Assertive community treatment incorporates norms, attitudes and values that are optimistic and supportive in the belief that people can and will recover from severe mental illness (Salyers & Tsemberis, 2007). According to the recovery framework, to ensure effective communication, trust and partnership between clients and practitioners, it is essential that the ACT practitioners convey the belief that participants can get well and stay well for long periods of time, work toward and meet goals, and lead happy and productive lives (Phillips & Burns, 2003).

Throughout my experience during my practicum, I observed the team to demonstrate qualities of compassion, patience and hopefulness in terms of the recovery process. During the triage process, ACT practitioners were open to accepting clients to the program, regardless of their reported diagnoses or noteworthy history (criminal involvement, serious addictions issues, and so on). The likelihood of recovery was discussed frequently in the ACT office, and small steps in recovery were always recognized and celebrated with clients and staff members. The genuineness and positivity demonstrated by the staff was reflected in the strong relationships fostered between staff and clients. Throughout my time at ACT, it was apparent that the mental health team truly cared about the client’s wellbeing and believed in the possibility of a positive future for many of their clients.

Social work has been viewed as the most value based of all professions (Wu, Tang, Lin & Chang, 2013). While the assertive community treatment team is comprised of several disciplines and not limited to social workers, the philosophy of ACT is comparable to many of the values and principles outlined in the CASW Code of Ethics (2005). For example, respect and dignity are
important values of the ACT program. The first value listed in the *Code of Ethics* (2005) is respect for the inherent dignity and worth of persons. This value discusses the longstanding commitment for social workers to uphold human rights and each person’s right to self-determination, to respect the diversity among individuals in terms of their unique rights and differences in their beliefs, and the importance of respecting the rights for clients to make choices based on voluntary consent (CASW, 2005).

ACT teams recognize the challenges associated with mental illness and participating in a treatment program and therefore, provide support and counsel to clients when required. For the duration of my time at ACT, I observed the staff to treat clients with the utmost respect and dignity. Decisions and treatment plans were always completed in partnership, to empower individuals and support clients in guiding their personal treatment journey. ACT staff was also available to provide information and options, but clients were responsible to make choices based on their informed consent, whenever safe to do so. If safety concerns were present, this was addressed honestly and justly with the client, prior to the course of intervention.

Pursuit of social justice is the second value defined in the *Code of Ethics* (2005). This value discourses the importance of providing resources, services and opportunities for individuals who are marginalized, disadvantaged, vulnerable and/or who have exceptional needs. Principles integrated in this value also include the importance of advocating for equal treatment and access to services, as well as promoting social development and challenging injustices (CASW, 2005).

Briefly following the intake process, the mental health team immediately begins the relationship with the client by attempting to eliminate barriers and connecting the client with external resources. For instance, homelessness and addictions are both common presenting issues
for new ACT clients. Therefore, the program works in partnership with housing programs to provide housing options to clients upon their admission to ACT. Addictions Services are also offered to clients when an addictions counselor is not part of the mental health service delivery team. These types of services are prioritized, because ACT recognizes that an individual’s ability to effectively manage their mental health is likely to be compromised without appropriate housing or shelter, access to medications, and so on. Therefore, assertive community treatment attempts to eliminate these barriers as much as possible. ACT teams work as advocates for their clients and connect clients with external services when necessary to ensure the client is supported as much as possible.
Chapter 3: Theoretical Frameworks for Practice

This chapter outlines theoretical frameworks for practice, focusing on strengths-based practice and anti-oppressive practice. The key principles of both frameworks will be highlighted. Advantages and disadvantages of this practice will be discussed, as well as the commonalities shared between strengths-based and anti-oppressive practice. I have chosen to focus on these two frameworks specifically, because I personally identify with them both in my social work practice and because they are important components of the ACT model.

3.1 Strengths-Based Practice

The strengths-based theoretical framework will be incorporated throughout this report. I have chosen this framework because the assertive community treatment model has been built on the foundation of the strengths-based perspective, and because this is a framework that I have always identified with in my social work practice. According to Corcoran (2005), this type of practice is a relatively new movement that has emerged in the helping professions, especially in social work. Historically, the dominant ideology focused on people’s problems and attention was focused on the weaknesses and limitations of people. In many circumstances, practitioners attempted to provide direction to clients by suggesting only how to fix their problems (Corcoran, 2005). Fortunately, these ideologies have been challenged and mental health service delivery is now focused towards a more positive perspective, emphasizing the strengths, capacities and abilities of individuals with severe mental illness.

In discussing the elements of the strengths-based perspective, Saleebey (1996) contends that “all must be seen in the light of their capacities, talents, competencies, possibilities, visions, values and hopes, however dashed and distorted these may have become through circumstance, oppression and trauma” (p. 297). Cohen (1999) also explains that this practice does not allow
professionals to focus on the shortfalls of their clients, rather “the strengths perspectives obligates workers to understand that, however downtrodden or sick, individuals have survived (and in some cases even thrived). They have taken steps, summoned up resources, and coped…” (Cohen, 1999, p. 461). Cohen (1999) argues that professionals trained to view their clients as human beings using their strengths and resources to cope with adversity have a much better chance of helping their clients find a means to improve their situations. While focusing on strengths and self-determination, this perspective also highlights the significance of “meeting the client where they are at” and building on those positive aspects. In congruence with the recovery model, Cohen (1999) states that the strengths-based perspective supports the belief that people who have suffered trauma or tragedy can continue to lead successful lives. This strengths-based perspective denies the premise that those who have suffered trauma will remain injured, disabled or “less than”. (Cohen, 1999). Vandevelde et al. (2017) contend that there are several main philosophies of the strengths-based model; they are as follows:

- Individuals who experience mental health problems have the capacity to grow.
- It is essential to move beyond deficits and give emphasis to strengths.
- The focus is placed on context and natural resources.
- The client is in control of their individual treatment or support process.
- The relationship between the client and partner is essential in fostering hope.
- Strengths-based practice should take place in natural surroundings/community.

There are many advantages of strengths-based practice; Vandevelde et al. (2017), states that in treating mental illness, strengths-based interventions contribute towards positive results in many areas including treatment retention, treatment satisfaction, education and employment rates, recovery promoting attitudes and service utilization.
Despite its evidence based success, the strengths perspective also has its disadvantages or public reservations. A common criticism about the strengths perspective is that it is excessively positive or too optimistic (Saleebey, 1996). Saleebey (1996) contributes to this statement advising that many practitioners and students argue that this type of perspective essentially downplays or ignores reality. In contribution to this ideology, some individuals express concern that strengths-based practitioners are ignoring how manipulative and dangerous some clients may be. Saleebey (1996) contends that strengths-based critics believe that certain individuals are too destructive and cannot be helped; therefore, mental health recovery would be impossible. Despite its criticisms, this theoretical framework has become a successful and positive approach to supporting individuals with SMI.

3.2 Anti-Oppressive Practice

The value base of assertive community treatment has also been developed through an anti-oppressive practice approach; a practice that incorporates many of the strengths-based perspectives as well (Larson, 2008). According to Larson (2008) anti-oppressive practice seeks to recognize the oppression that exists within society and challenges the social relations and structures that perpetuate social injustice and inequality. This approach focuses on power sharing and egalitarian relationships by emphasizing the importance of recognizing power imbalances and working towards changes to equalize the balance of power (Larson, 2008).

ACT recognizes the history of stigmatization of the SMI population, and implements the anti-oppressive practice framework in an attempt to eliminate the oppressive barriers experienced by many of the ACT participants (Larson, 2008). Larson (2008) indicates that anti-oppressive practice involves self-reflection and understanding of power and oppression, and recognizing how individual’s behavior can perpetuate that oppression. Arboleda-Florez and
Stuart (2012) argue that stigmatization and stereotypes of mental illnesses have accumulated over time, rather than improved. Research also suggests that mental health professionals are considered some of the most stigmatizing groups, although they are often unaware of their own behaviors and biases (Arboleda-Florez & Stuart, 2012).

Several commonalities are shared between strengths-based perspectives and anti-oppressive practice. The elements and principles of both frameworks have become an important part of social work practice, especially in the area of mental health service delivery. Both strengths-based and anti-oppressive practice focus on a person-centered philosophy that aims to develop alliances with clients and empower individuals (Saleebey, 1996). When these frameworks are incorporated in the helping profession, individuals with SMI can be better understood and discriminatory notions can be identified and challenged. Building safe and respectful environments for marginalized people, challenging inequality and promoting egalitarian relationships are all important goals of anti-oppressive practice and these values also support the principles and values of the strengths-based framework (Saleebey, 1996).
Chapter 4: Mental Illness

The next section of this report is a review of literature regarding mental health concerns within the Canadian context. Stigmatization of mental illness, and its impacts on the mental health population will be reviewed. This chapter will also outline the historical shift in treatment of mental illness, the deinstitutionalization movement, and its substantial criticisms. The development of the service delivery model of ACT will be discussed, as well as the primary components and foundations of the model.

4.1 Severe Mental Illness

According to the Mental Health Commission of Canada (2012), one in five Canadians (nearly 7 million people) experience some type of mental illness. Mental illness is a term used to refer to “diagnosable mental disorders that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) and associated with distress and/or impaired functioning” (Fenton, White, Gallant, Hutchinson & Hamilton-Hinch, 2016, p. 347). Mental health problems or illnesses may range from common mental health problems such as depression and anxiety to more severe mental illnesses such as schizophrenia and bi-polar disorder (Fenton et al., 2016).

Severe mental illness (SMI) is defined as a “mental disorder [i.e. psychotic disorders including schizophrenia, manic depression or severe depression of severe neurotic conditions and personality disorders] of such intensity that it disables people, preventing them from functioning adequately…” (Askey, 2004, p.12). People diagnosed with SMI often experience a combination of complex social and clinical needs. For instance, there are numerous barriers that negatively impact the health and wellbeing of individuals with SMI. The Mental Health Commission of Canada (2012) report that adults with severe mental health problems have higher rates of chronic
health conditions including hypertension, diabetes and cardiovascular disease. Obesity and chronic fatigue are also common health concerns experienced by this population (Fenton et al., 2016). In addition, issues of social inclusion and full citizenship of individuals with mental illness within their communities are also substantial challenges for the SMI population (Fenton et al., 2016).

Research suggests that men and women experience mental illness differently, specifically in the type of mental illnesses they have. Karin-Schon (2010) states that men are more likely to have substance abuse disorders and antisocial behaviors. Forchuk, Jensen, Csiernik, Ward-Griffin, Ray Montgomery and Wan (2009) also argue that men with schizophrenia are more likely to commit suicide than women. However, women are twice as likely to have a mood disorder and more likely to suffer from depressive episodes (Forchuk et al., 2009). For women with concurrent disorders, they are also at a greater risk in developing secondary health problems like sexually transmitted infections (Forchuk et al., 2009).

In terms of recovery, research shows that women are more likely to experience more positive outcomes during the recovery process such as fewer negative symptoms, fewer relapses and shorter hospital stays (Karin-Schon, 2010). Karin-Schon (2010) attributes this to the female advantage due to hormones and organic difference in the brain and to the fact that women normally experience mental illness much later in life as compared to men. While Forchuk et al. (2009) agrees that biology may influence an element of mental illness, the author also highlights the influence of gender attitudes, behaviors and sociocultural roles and relationships in relation to mental illness. Forchuk et al. (2009) argues that in moving forward, it is essential to take sex and gender into account when working with the SMI population to effectively address both men’s and women’s unique needs.
Forchuk et al. (2009) also refers to a five-year longitudinal Canadian study, Mental Health and Housing, through the Community Research University Alliance which aimed to explore the differences and similarities between men and women who had a history of mental illness. An important finding in this study was a correlation between sex and homelessness, demonstrating that men are more likely than women to be homeless (Forchuk et al., 2009). This study also indicated that women without housing will form relationships with men to avoid being in a shelter; however, these relationships may also be abusive and dangerous.

Although women are less likely to be homeless, a general finding of the Mental Health and Housing study is that homelessness, poverty and a lack of community programming continues to be a prevalent issue for both men and women with severe mental illness (Forchuk et al., 2009) Forchuk et al. (2009) indicates that this appears to be a structural issue, influenced by not only a lack of information and research, but also by stereotypical attitudes and stigmatization. With the information provided above, it is important to note the unique and individual needs of both men and women, as well as the influence our society has on this population, which will be discussed throughout this report.

4.2 Stigmatization of Mental Illness

Social exclusion and the lack of parity for individuals with experiences of SMI are due to the prevalent stigmatization against those with mental illness. Stigmatization is a process that occurs when there is a power differential (Arboleda-Florez & Stuart, 2012). Ye et al. (2016) define stigma associated with mental illness as “a negative attitude, based on prejudice and misinformation that is triggered by a marker of illness…” (p. 532). Arboleda-Florez and Stuart (2012) contend that “through the stigmatization process, people with a mental illness are
marginalized, disenfranchised, excluded, and denied the human rights and social entitlements that others take for granted” (p. 459).

Unfortunately, individuals living with SMI experience stigmatization in everyday aspects of life. Research has revealed that much of the public share the notion that people with severe and persistent mental illness are incapable of controlling their behaviors, have an inability to recover, and have tendencies to be unpredictable, violent and dangerous (Arboleda-Florez & Stuart, 2012). As a result, these views of the public essentially perpetuate prejudice and discrimination, causing detrimental effects on the SMI population (Arboleda-Florez & Stuart, 2012).

Covarrubias and Han (2011) argue that this type of discrimination has serious consequences for individuals with SMI and acts as a significant barrier to receiving effective care. Refusal to seek treatment, decreased quality of life, fewer job opportunities, and delays in seeking healthcare, decreased opportunities to obtaining housing and decreased self-esteem are all further examples of how stigmatization negatively affects individuals with mental illness (Covarrubias & Han, 2011). Consequentially, marginalized people including individuals with SMI experience higher rates of poverty and homelessness, criminalization and general social exclusion (Arboleda-Florez & Stuart, 2012). Arboleda-Florez and Stuart (2012) indicate that, among individuals with severe and persistent mental illness, between 70 to 90 percent are considered unemployed. Furthermore, the overrepresentation of individuals with mental illness is substantial, as an estimated 15-20% of prison inmates are reported to suffer from SMI (Fenton et al., 2016).
4.3 The Historical Shift in Treatment of Mental Illness

Throughout history, the mistreatment and segregation of people with SMI has been an ongoing issue for people with mental illness. A lack of appropriate health care services has been a prevalent issue for the mental health population (Phillips & Burns, 2003). Historically, most persons with SMI were treated in large mental hospitals on an inpatient basis (Phillips & Burns, 2003). In the 1950s and 1960s, the deinstitutionalization movement resulted in a significant change in the locus of treatment for this population (Phillips & Burns, 2003).

Deinstitutionalization became popular in North America during the 1960s and 1970s due to the shifting public attitudes regarding involuntary commitment, a policy that allowed the state to confine patients to mental residences without their consent. In 1961, Canadian sociologist, Erving Goffman published a critique of US psychiatric care in which he characterized mental hospitals as being examples of social institutions (Goffman, 1961). Goffman condemned mental institutions as practicing inhumane forms of social control to keep the vulnerable and marginalized mental health clients out of public sight (Goffman, 1961). These criticisms resonated with the broader deinstitutionalization movement (Phillips & Burns, 2003).

Rather than remaining in hospital, persons with severe mental illness began to be discharged from hospital when medically stable and integrated back into the community. Although the movement of deinstitutionalization was momentous, many argue it was a flawed strategy. Sadly, communities did not receive the funding they required to provide care to mental health clients. Therefore, due to fragmented care between agencies and lack of appropriate resources, many persons with severe psychiatric disorders did not receive the care they required, and would require readmission to hospital shortly after their discharge (Philips & Burns, 2003). Askey (2004) stated that as a result, “revolving door hospitalizations” were accepted as
inevitable. Despite the movement, societal negative attitudes of individuals with mental health remained the same. At worst, people diagnosed with severe mental illness (who did not cope well following hospital discharge) were labeled as noncompliant, treatment resistant or unmotivated and unfortunately, their needs went unmet (Phillips & Burns, 2003, p. 9). Unfortunately, deinstitutionalization resulted in increased homelessness and even imprisonment.

In their study regarding mental health professionals at Mendota Mental Health Institute, Bond, Mueser and Latimer (2001) stated that the current mental health service delivery was failing individuals with severe mental illness. Their research demonstrated several inadequacies that suggested that people with SMI were not receiving the services they needed to be successful in their recovery (Phillips & Burns, 2003). For instance, following hospital discharges, researchers found that the amount of services and support offered to individuals with SMI reduced considerably, and on the occasion when services were available, they were often only provided for a limited amount of time. Furthermore, if programs and services were unavailable to the patient, there would be no one responsible to advocate or connect individuals to services. Despite the teaching and skills learned on an inpatient basis while in hospital, it was also determined that most individuals with SMI were unable to transition those skills to live successfully in the community. In fact, people diagnosed with SMI were reported to experience even more stress associated with the change and new experiences related to ongoing hospital and community transitions (Askey, 2004). With this background on the treatment of individuals with SMI, I will now turn to the discussion of the Assertive Community Treatment Model in Calgary, Alberta.
4.4 The Assertive Community Treatment Model

In the early 1970s, Marx, Stein and Test responded to the concerns discussed above by designing ACT, a service delivery model aimed to support individuals with SMI to become integral members of their communities (Marx, Stein & Test, 1973). ACT can be defined as “a flexible and creative team-based approach to working with the complex needs and wishes of a clearly defined group of people. This group is frequently referred to as experiencing severe and persistent mental health problems, and as being hard-to-engage or resistant to services. They have generally been inadequately served in the mainstream development of community and inpatient mental health services” (Askey, 2004, p. 13). Essentially, ACT is a comprehensive community based model for delivering treatment, support and rehabilitation services to individuals with SMI who experience the most severe symptoms and suffer from the utmost level of functional impairment (Phillips et al., 2001). Generally, this program serves clients who fail with traditional health services, or are generally unwilling to engage in services. Mancini et al. (2009) states that ACT is specifically designed for persons with severe mental illness who have a recent history of psychiatric hospitalizations, criminal justice involvements, homelessness and substance abuse.

The assertive community treatment model is considered one of the most effective and best researched mental health treatment models (Bond et al., 2001). It is also the highest intensity service that can be received in the outpatient setting (Finnerty et al., 2015). ACT consists of a trans-disciplinary team of mental health professionals who work together as a team to support individuals with SMI. ACT teams work in the community setting to support a holistic approach to providing a broad range of services that are critical to an individual’s functioning. While services vary depending on the needs of the client, ACT support is offered in activities of daily
living, locating specialized health care services, accessing safe and affordable housing and obtaining financial assistance. Moreover, this model also offers independent living skills training, recreational programming and individual counselling.

In comparison to more traditional approaches to care, ACT has been recognized to considerably reduce psychiatric hospitalizations and emergency medical care (Bond et al., 2001). According to Bond et al. (2001) assertive community treatment programming provides more independent living, better control of psychiatric symptoms, increases housing stability, higher rates of employment and overall, provides a better quality of life for individuals with SMI (Bond et al., 2001). In addition, ACT is also known for its effectiveness in optimizing engagement, preventing and anticipating crisis and reducing risk (Askey, 2004).

It is argued that mental health programs that adhere closely to the assertive community treatment principles are more likely to get the greatest outcomes (Phillips & Burns, 2003). There are many components and principles of ACT that support and influence the success of this program. The ACT model is very much guided through the principles of the recovery model, as well as the stress vulnerability model. In terms of ACT ideologies, this model is focused on the principle that recovery is a process that can be accomplished through ongoing treatment and rehabilitation (Phillips & Burns, 2003). Additionally, ACT also takes the stress-vulnerability model into consideration, acknowledging how negative life experiences and stressors may impact the recovery of an individual with SMI (Phillips & Burns, 2003). While supporting clients through the recovery model and stress vulnerability model frameworks, assertive community treatment recognizes that recovery is an individual process and assists in minimizing stressors to support the recovery process as best as possible.
4.5 Components of Assertive Community Treatment

The ACT model is comprised of several components that contribute to its’ effectiveness. Trans-disciplinary staffing is a key element in this model. The clinical team is comprised of mental health professionals including psychiatrists, registered nurses, occupational therapists, outreach workers, social workers, and recreational therapists. This representation of different disciplines allows for comprehensive care of individuals and for practitioners with various professional training and skills to work closely together and blend their knowledge and skills, as opposed to a multidisciplinary team that maintains their own professional boundaries, a trans-disciplinary perspective encourages collective efforts for best ideas or treatment approaches. In addition, this model allows for staff to continue to provide client care even when there is a staff shortage, while also preventing a disruption in treatment and ensuring continuity of care when there is staff turnover.

With the implementation of a team approach, assertive community treatment practitioners do not have individual caseloads; rather, the team shares responsibility for each client. This allows for ACT staff to maintain frequent contact with each client and to permit respective practitioners to contribute their personal expertise and skills towards everyone’s best interests (Stuen, Rugkasa, Landheim & Wynn, 2015). The assertive community treatment team also maintains low caseloads and engages in frequent team meetings to follow up with clients closely and discuss and assess ongoing treatment plans and goals (Stuen et al., 2015). Additionally, low caseloads provide the ability for ACT teams to offer intensive treatment, while also having the time to intervene proactively during crises. Also, low caseloads allow for assertive community treatment practitioners to integrate individualized services into practice; a
Central principle in ACT that ensures that treatments and supports are individualized to accommodate the needs and preferences of each client (Bond et al., 2001).

Integration of services is another important component of the ACT model (Stuen et al., 2015). This element helps to prevent inconsistencies and fragmented service delivery, a common occurrence when different agencies and programs are all responsible for different aspects of a client’s care (Stuen et al., 2015). Within the assertive community program, an integrated approach for service delivery is offered by tailoring individual goals and needs for each client. With the trans-disciplinary structure, clients can receive a variety of services from the clinical team, without requiring referrals to other programs or agencies. ACT is designed to provide an array of different services including support regarding medications, symptom control and physical health, to more practical issues such as support concerning employment, housing and activities of daily living and so on.

Assertive outreach is also a leading element in the ACT model (Bond et al, 2001). As mentioned previously, this program serves clients who have a history of noncompliance with traditional mental health issues. The ACT teams, however, are persistent in engaging reluctant clients in treatment. The teams do not automatically terminate with clients when concerns arise or when appointments are missed, rather, ACT practitioners outreach to clients in a variety of ways. For example, members of the clinical team frequently attend the homes of clients when their appointments have been missed, provide transportation when needed, and accompany clients to appointments or programming. Assertive community treatment teams are sometimes willing to provide emergency financial assistance if needed, and can offer assistance with practical tasks such as completing income tax forms, or moving to a new apartment. Providing
assertive outreach not only encourages clients to participate in programming, but also helps to foster positive relationships between clients and staff (Bond et al., 2001).

Intensive contact in the community is an important component of assertive community treatment (Bond et al., 2001). As opposed to traditional mental health services (where the clients usually attend the office to receive services). ACT teams provide in vivo services commonly meeting with clients in community settings, or as mentioned previously, in the homes of the clients (Bond et al., 2001). In fact, the assertive community treatment model suggests that 80% of contacts should take place outside the office (Bond et al., 2001). According to Bond et al. (2001), contacts in natural settings in which people live, work or interact with others are much more effective than office or hospital visits. It is argued that skills taught in clinical settings do not always transfer well to natural settings (Bond et al., 2001). In their conclusion, Bond et al. (2001) state that assessments completed in vivo are more accurate, because behaviors can be assessed directly in the clients setting. For difficult to engage clients, ACT teams can provide medication deliveries or medication observations in the client’s homes, while still managing to complete a brief assessment to ensure the safety of the individual (Philips & Burns, 2003).

Although the effectiveness of assertive community treatment has been well supported by research, the assertive community treatment model has also been identified to have some disadvantages. Herman (2014) argues that for public systems who have invested heavily into the ACT model, the main shortcoming of assertive community treatment is related to cost and capacity (Herman, 2014). Given that assertive community treatment is a time unlimited model, many clients access these services for a lengthy amount of time (sometimes several years) and essentially, discharge from the program is not emphasized or prioritized. Consequently, this has
contributed to longer wait lists and fewer openings. Furthermore, the principle of maintaining small caseloads also contributes to this issue.

4.6 Community Treatment Orders

As mentioned previously, a main challenge for mental health services is the ability to provide services to individuals who refuse to engage with psychiatric treatment and medication regimes (Hatfield et al., 2001). In January 2010, community treatment orders were introduced as a new approach in Alberta to improve medication compliance, expand service options available to clients and care providers, and ideally, to minimize hospitalizations. A community treatment order, under *The Mental Health Act*, is a tool intended for medication adherence purposes, for individuals with severe mental illness who are in the community. The community treatment order may be described as a treatment or care plan that may also include mandatory medication regimes and obligatory appointments with mental health care professionals. By using the criteria of *The Mental Health Act*, two physicians determine if a person is suitable to be on a CTO. Community treatment orders are specifically intended for individuals who are likely to decompensate in the community, suffer substantial mental or physical deterioration, or be likely to cause harm to themselves or others (Hatfield et al., 2001). Essentially, a CTO mandates the delivery of psychiatric treatment and mental health services (Hatfield et al., 2001).

Community treatment orders are a common tool applied in assertive community treatment. To fully understand this process, I was provided with the opportunity to partner with a community treatment order coordinator employed within Alberta Health Services. The coordinator primarily works on an inpatient basis at several of the Calgary hospitals. The coordinator’s role includes discharge planning with clients who are newly mandated to community treatment orders, completing paperwork for CTO renewals, completion of
applications and cancellations, managing noncompliance issues, organizing and participating in panel reviews, as well as guiding and supporting the psychiatric units and assertive community treatment teams concerning proper CTO procedures and protocol.

During my practicum, I was also involved in supporting and supervising several clients who were mandated to community treatment orders. Assertive community treatment participants who were assigned to a CTO were observed to attend programming minimally or frequently, depending on their treatment order conditions. Typically, ACT clients attended the agency monthly, bi-weekly or weekly for injection clinics. This provided me and the assertive community treatment staff with the opportunity to complete ongoing and frequent assessments on clients, but to also assess whether the individual was adhering to the conditions of the community treatment order. If clients were observed to breach conditions previously outlined in the community treatment order, ACT staff would be obligated to report any noncompliance. In the event of non-compliance, clients were often re-admitted to hospital to ensure their personal safety, as well as the safety of the community.

Near the completion of my practicum, I also participated in a panel review, a required process under the Mental Health Act. Essentially, review panels make decisions about community treatment orders, determining to either cancel a CTO or refuse to cancel an order. Review panels consist of four members, a chair or vice chair (who must be a lawyer), one psychiatrist, one physician, and one member of the public. Clients are also encouraged to attend review panels, with the support of their mental health worker. During the panel review, staff usually accompanies the client for support, especially if the client has concerns or feels apprehensive about the meeting, as this type of review may often feel intimidating for clients. It is also helpful for assertive community treatment team members to attend the consultation to
review concerns, but also to serve as an advocate and highlight client’s strengths and positive gains in treatment.
Chapter 5: Practice Models of Service Delivery

Both the recovery and stress-vulnerability model are discussed in detail in the chapter that follows. The ACT model may be best understood when viewing the model through the practice models of recovery, and the stress-vulnerability model. The roles of cognitive behavioral therapy and cognitive behavioral social skills training as effective strategies for treatment are also reviewed. My personal involvement in implementing these practice models of service delivery throughout the practicum is also discussed.

5.1 The Recovery Model

One of the foremost goals of assertive community treatment is to support the process of recovery from severe and persistent mental illness (Phillips & Burns, 2003). The strengths-based recovery model, a framework with underlying principles of hope, empowerment, choice and self-determination, is a main concept incorporated in assertive community treatment (Fenton et al., 2017). The recovery framework supports the expectation that people who experience severe mental illness can pursue a life in which mental illness is not the driving factor of their existence (Fenton et al., 2017). Overall, this model supports the principle that recovery from SMI is increasingly possible.

The Mental Health Commission of Canada defines recovery as “living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems” (Mental Health Commission of Canada [MHCC], 2012, p. 15). This framework supports the notion that people with mental illness have the same wants and needs as everyone else. The recovery model also acknowledges that mental illness symptoms may be ongoing, but recognizes the capabilities and potential of people with mental illness. Overall, it emphasizes
individual, family and community strengths and the likelihood for individuals with SMI to live, work and participate fully in their communities (Salyers & Tsemberis, 2007).

ACT programs embrace several recovery oriented practices that are intense and long-term in nature (Salyers & Tsemberis, 2007). Long term services allow the team to engage with clients and develop relationships with individuals to support them through their recovery process. After years of relationship building and direct involvement, ACT staff members can assess clients quickly and become familiar with each client on an individual level, noticing even small steps in recovery and celebrating them. Furthermore, through the establishment of positive relationships, staff can better anticipate relapses and crises and provide intervention as early as possible. Additionally, Salyers and Tsemberis (2007) argue that the ACT trans-disciplinary team is also well suited for fostering recovery because the team works in a holistic manner, supporting individuals in the areas of employment, relationships, leisure activities, finances and illness management; all important components of the recovery process (Salyers & Tsemberis, 2007).

Rather than traditional clinician driven approaches, ACT teams are designed to offer full partnership with clients and their families. This is followed within all aspects of ACT services including setting goals and priorities, sharing decision making authority, as well as developing treatment plans that clients have the option to agree or disagree throughout the treatment process (Bond et al., 2001). Not only is this type of service delivery more client centered, but it also provides a sense of empowerment for clients. Similarly, this type of service delivery coincides with the principle outlines in the Code of Ethics (2005) which states, “Social workers uphold each person’s right to self-determination, consistent with that person’s capacity and with the right of others” (p. 4).
As a social worker, guiding treatment through recovery oriented principles served as a rewarding experience during my practicum. I found that working in the community allowed me to work in close partnership with clients, and it permitted me to establish unique and positive relationships with many clients, while supporting their recovery journey. My role included provision of supports and education in areas of individuals taking responsibility to better control their own symptoms and stress triggers, offering encouragement, and helping clients in setting personal goals and implementing strategies to work towards achieving their goals. Most importantly, I felt that while working in partnership with clients, I contributed to a portion of the empowerment and self-determination they could identify with, through the support of the ACT program.

5.2 The Stress-Vulnerability Model

The stress-vulnerability model is a framework incorporated in the ACT program that provides structure to understand the onset and progressions of mental illness (Phillips & Burns, 2003). According to the stress-vulnerability model, an episode of SMI involves two factors, biological vulnerability and stress (Phillips & Burns, 2003). When these two factors collide, the stress-vulnerability framework suggests than an episode of major mental illness, such as schizophrenia or bi-polar disorder, may occur (Phillips & Burns, 2003).

When discussing the biological factors of the stress-vulnerability model, researchers suggest the elements include genetics, biochemical agents, as well as biological development (Phillips & Burns, 2003). This framework also proposes that stressors can be as significant as the death of a loved one or as minor as a daily mishap, such as missing the bus. Despite how stressful the event may be, for individuals with SMI, it is still a change that can promote a
substantial amount of strain and anxiety, which can likely contribute to much vulnerability for the SMI population, including a higher risk of relapse (Phillips & Burns, 2003).

Through the implementation of the stress-vulnerability model, ACT practices numerous approaches to address these concerns and ultimately attempts to alter or intervene in the patterns described in the stress-vulnerability model (Phillips & Burns, 2003). Pharmacological treatment of mental illness is an example of a practice supported by the ACT team in an attempt to alter biological processes, as numerous psychotic medications have been proven to alter chemicals within the brain to reduce or eliminate psychiatric symptoms (Phillips & Burns, 2003). While medication can be an effective treatment for illness management, the side effects to this medication can be extensive (Stomski, Morrison & Meehan, 2016). To ensure proper monitoring of medication and side effects, clients meet regularly with the ACT psychiatrist and general practitioner for follow up appointments to ensure the suitability of each person’s medication regime. Additionally, the team maintains a close working relationship with clients to provide medication monitoring, administration (when needed) and ongoing assessment of clients to make certain their symptoms and side effects are being managed appropriately.

Changing an individual’s risk of exposure to stressors is another way that ACT can alter the stress-vulnerability model (Phillips & Burns, 2003). Challenges such as job loss, history of repeat hospitalizations and family breakdown are common experiences for individuals with SMI. Therefore, participants of ACT require intensive support to deal with those negative and taxing experiences. The ACT team works together to ensure individuals feel supported. Teams are flexible in the services they are willing to provide, and for that reason can communicate with family members and external resources and can provide support to individuals who are experiencing the repercussions of significant and minor stressors.
It is also important to note that even changes that may appear positive, such as moving to a new apartment or participating in a new recreation activity, can be challenging for the SMI population, as changes and life transitions may trigger stress for some individuals. ACT recognizes these barriers, and tries to prepare for what skills, support and resources people need in order to minimize stress as much as possible.

5.3 Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a well-known strategy that has also been found to be effective for treating those with severe mental illness (Herman, Shireen, Bromley, Yiu & Granholm, 2016). Many hospitals and mental health agencies now incorporate CBT treatments in mental health service delivery (Herman et al., 2016). This form of psychotherapy involves the client and the therapist actively working together to help the clients recover from mental illness (Herman et al., 2016). CBT has shown to be effective for treatments for a variety of problems ranging from mood and anxiety disorders, to substance use and personality disorders (Herman et al., 2016). According to the American Psychiatric Association, CBT is also considered to be an evidence based treatment used to alleviate severe symptoms of schizophrenia, and has also shown great success in the reduction of symptoms in mental illness, specifically auditory hallucinations (Herman et al., 2016).

Overall, cognitive behavioral therapy emphasizes the relationships between thoughts, feelings and behaviors (Herman et al, 2016). In CBT, it is argued that thoughts and interpretations of events evoke negative feelings, rather than the actual events themselves (Herman et al., 2016). This model also argues that certain thoughts or beliefs can significantly affect individuals in their daily lives (Herman et al., 2016). In recognizing this, CBT emphasizes the principle that symptoms and dysfunctional behaviors can be improved by changing an
individual’s adverse thinking and beliefs (Herman et al., 2016). Essentially, this is an intervention to alleviate suffering of the individual by assisting the client to understand their problems in a healthier, adaptive manner (Herman et al., 2016). While focusing on specific symptoms, cognitive behavioral therapy incorporates techniques to help manage delusions, hallucinations and negative symptoms of mental illness (Herman et al., 2016).

CBT is a strategy that I have incorporated in my counselling practice for several years, but during my practicum with assertive community treatment I built on my skills and developed a more competent working knowledge of this type of therapy. I also learned a variety of cognitive behavioral strategies that I was unfamiliar with prior to this experience. While ACT maintains a shared caseload, weekly individual sessions are case managed by certain members of the ACT team to ensure that clients are receiving the intensive supports they need. Throughout the course of the practicum, I was responsible to meet with several clients on a weekly basis for one-to-one counselling sessions. During this counselling, my treatment approach was guided by several CBT techniques that were found to be useful during treatment.

For example, while working with many of my clients, cognitive behavioral strategies, including cognitive restructuring and behavioral activation, were incorporated as a focus of treatment. This involved identifying and challenging distorted thoughts, as my client was engaging in frequent negative self-talk, which perpetuated to feelings of low self-worth and irrational fears that other individuals and community members thought ill of her. Furthermore, these types of cognitive distortions also decreased the client’s activity levels and social engagement. After practicing many CBT techniques and becoming more familiar with the cognitive behavioral model, the client appeared to gain a sense of understanding regarding the relationship between thoughts, feelings, and behaviors. Once this had been accomplished, I was
able to support the client to counteract negative thoughts as much as possible. By challenging distorted thoughts, the client could engage in more social and recreational activities with others. Near the end of the practicum, the client was observed to participate in recreation activities with others, which was profound, considering the lack of confidence and self-esteem she presented with at the beginning of our working relationship. Although it is likely that she still experiences some distortions in thinking, the client now has the skills to identify and challenge those thoughts to continue to participate in social environments and in the community.

5.4 Cognitive Behavioral Social Skills Training

As previously noted, impairments in social skills and negative thinking patterns are very much a reality for numerous individuals with SMI, presenting many challenges for this population (Granholm et al., 2015). While CBT has been identified as evidence based strategy in mental health, cognitive behavioral social skills training (CBSST) is also an intervention that is proven to be an effective strategy for service delivery for SMI (Granholm et al., 2015)

Cognitive behavioral social skills training is a psychosocial intervention that has demonstrated much success in facilitating positive outcomes for individuals with severe and persistent mental illness (Granholm et al., 2015). CBSST is a recovery oriented group therapy that is regularly practiced in the context of assertive community treatment and an intervention that integrates techniques from both cognitive behavioral therapy and social skills training, focusing less on symptoms and more on functioning and recovery (Granholm et al., 2015).

By combining both principles of cognitive behavioral therapy and social skills training, therapists can use social skills training to teach new skills and CBT to cope with thoughts that interfere with an individual’s quality of life (Herman et al., 2016). Generally, CBSST is comprised of modules including cognitive training skills, social skills training and problem-
solving skills (Herman et al., 2016). According to Herman et al (2016) all three modules are directed towards assisting participants in achieving their individual goals. The cognitive module teaches participants how to correct dysfunctional thoughts that interrupt goal oriented activities (Herman et al., 2016). In terms of the social skills module, it teaches social skills to improve engagement and communication during social interactions (Herman et al., 2016). In addition, the problem-solving methods guide participants through the process of breaking down their problems, weighing positives and negatives and developing a realistic plan to move forward (Herman et al., 2016).

According to Granholm et al. (2015), cognitive behavioral social skills training is an innovative and comprehensive approach to improving psychosocial functioning in individuals with SMI. Herman et al. (2016) supports this statement, stating that several outcomes of randomized clinical trials have shown that individuals who received cognitive behavioral social skills training performed significantly better on measures of social functioning and independent living, compared to individuals who did not receive this training (Herman et al., 2016). Furthermore, evidence suggests that the impact on cognitive behavioral social skills training regarding independent living skills have been shown to persist up to one year after the completion of cognitive behavioral social skills training (Herman et al., 2016).

Unfortunately, when I began my practicum, a main portion of the CBSST program that was being offered by ACT had already been completed. To prevent disruption or interfere with the intervention, I chose to participate only as an observer. With verbal permission from the participants in the group, I observed six weekly sessions through a two-sided mirror. I was accompanied by another team member (a psychiatric nurse) who was available to answer questions and debrief each session with me.
After observing 6 of the 12 CBSST sessions, I established a much better understanding of the role of CBSST and gained a familiarity of the modules and material discussed in each session. In doing so, I felt more prepared for my “one to one” sessions with clients, as I incorporated many of the learned strategies during my individual sessions with clients. In addition, the opportunity to observe clients through a two-sided mirror was helpful in identifying both the challenges and strengths experienced by the participants. This was beneficial, because as an observer, I learned an abundance of information regarding the clients by only observing their interactions and participation within the group setting. My observations and assessments from CBSST provided me with more opportunities for direct practice as I could then identify who may require more support or more “one to one” time. Furthermore, my relationships strengthened with clients, as I could spend more time with the group participants, often helping with cognitive behavioral social skills training homework and preparing for upcoming group sessions.

Although facilitating a group could not be accommodated during my practicum, I learned many skills pertaining to group work and clinical strategies for group facilitation. Both facilitators of the CBSST group were open to my involvement in helping to prepare for each session and allowed me to complete the necessary chart documentation for each client following the group sessions. I looked forward to my involvements with CBSST on a weekly basis, and felt that this experience most definitely enriched my practicum experience.
Chapter 6: Assertive Community Treatment Strategies

ACT is argued to be one of the best researched treatment models in mental health service delivery (Bond et al., 2001). Research suggests that outcomes are more valuable and successful when the ACT treatment model is closely followed (Verhaegh, Bongers, Kroon & Garretsen, 2009). There are several clinical strategies and principles incorporated in the ACT model that contribute to the success of the program. Case management, medication management, music therapy, community recreation programs, coordination of care and liaising of services are all essential components of ACT treatment. These strategies support the process of recovery and contribute to the overall success of the program and the improved level of functioning for ACT participants. These are reviewed in detail below.

6.1 Case Management

Case management is an effective strategy for delivering comprehensive care for persons affected with severe mental illness; this is a common principle implemented in ACT treatment delivery. Askey (2004) states that case management can be described as “a process where a single person takes responsibility for maintaining long term supportive relationship with a patient…its function is to assist patients to identify, secure and sustain the range of internal and external resources they need to live as independently a life as possible in the community” (p. 12).

In the service area of mental health, typical goals of case management include preventing hospitalizations, improving quality of life and improving client functioning (Askey, 2004). While there are many different models of case management, traditional case managers often have large caseloads and complete various activities for their clients including service planning, assessment, and advocacy. Most case management programs have the main responsibility for their clients and
their role is largely occupied by the task of brokering services from other agencies or providers (Askey, 2004).

ACT practices a model of care that diverges from the traditional case management role and implements a more comprehensive model (Askey, 2004). ACT provides treatment and rehabilitation, in addition to providing typical case management functions (Askey, 2004). In this model, there is a low client to staff ratio to ensure adequate individual needs are met (Askey, 2004). Rather than having individual caseloads, ACT team members share caseloads, resulting in frequent contact with each client, as well as the opportunity for different team members to contribute their individual skills. Essentially, the team as a whole is responsible for assuring each client is receiving the services needed to live in the community and reach personal goals. Askey (2004) argues that the team approach leads to a continuity of care and an ongoing supportive environment. Through a shared caseload model, team members recognize the importance of the contributions of other disciplines and make a commitment together, to implement service plans and support clients as best as possible.

Shared caseloads are an approach to treatment that was unfamiliar to me. Initially, I questioned that some clients may “fall through the cracks”. However, I soon learned that this type of service delivery was effective when implemented through the ACT team. Effective communication, daily huddles with team members and communication boards ensured that all clients were receiving the services and support they required. In addition, weekly clinical meetings with the entire ACT team helped to identify the needs of each client. For a client who was observed to be having a difficult week, ACT staff would ensure to provide additional support for that specific individual. I did not observe any negative impacts of this type of service delivery, and I attribute that to the great sense of communication the ACT team maintained daily.
Since this service model involves a variety of different disciplines and areas of expertise, disagreements or variances regarding client treatment were sometimes identified between the team. To address these concerns, it was usually discussed as a team. And if necessary, direction was provided from the team leader. For the most part, however, the team was observed to communicate and express their concerns in a positive and treatment focused manner. These conversations were important, and it was clear that the ACT team members were all focusing on the best interests of the client.

6.2 Medication Management

Medication management is also a key principle in the treatment of mental illness and an important component in assertive community treatment (Stomski et al., 2016). Psychotropic medications are used to reduce or eliminate symptoms of mental illness, and may also assist in helping to prolong the period between episodes of illness (Phillips & Burns, 2003). According to Stomski, Morrison and Meehan (2016) numerous studies support this, identifying antipsychotic medications as an instrumental strategy in enhancing outcomes for clients, including improved positive symptoms and reduced risk of relapse (Stomski et al., 2016).

Although medication is considered one of the key cornerstones in treating severe mental illness, side effects of psychotropic medications can be substantial, greatly impacting the quality of life of the SMI population (Stomski et al., 2016). Parkinsonism, akathisia, tardive dyskinesia and substantial metabolic effects are all severe side effects associated with antipsychotic medication (Stomski et al., 2016). According to Stomski et al. (2016), 80% of mental health service users prescribed antipsychotic medication also experience troubling side effects including sedation, hypersomnia, insomnia, sexual dysfunction, dry mouth, constipation, urinary problems and dizziness (Stomski et al., 2016).
As outlined above, antipsychotic medications are necessary in the management of mental illness, however, they present many challenges and barriers to the quality of life and health of mental health service users. Due to the significant side effects and challenges associated with antipsychotic medication, non-medication adherence is a common outcome for many individuals with SMI (Stomski et al., 2016). Stomski et al. (2016) refers to several studies that report that at least 50% of all mental health service users are not adhering to prescribed antipsychotic medication. According to Manuel, Covell, Jackson and Essock (2011), non-medication adherence rates among individuals with schizophrenia range from 25% to 75%. Inconsistent or a lack of medication adherence can have detrimental consequences for individuals with severe and persistent mental illness (Manuel et al., 2011). Increased rates of relapse, hospitalization and self-harm are all implications related to inconsistencies in taking prescribed medication (Manuel et al., 2011).

Close medication management and monitoring was a key strategy implemented by myself, and the ACT team, to improve medical adherence and minimize many of the serious implications associated with inconsistent medication use. Ensuring the effective uses of medications, monitoring appropriate dosages, administering medications and monitoring side effects of medications are all responsibilities that we prioritized as an ACT team. Strategies implemented by our ACT staff to ensure effective medical adherence included: frequent contact and assessment of clients, ongoing one-to-one counselling sessions, accompanying of clients to follow up appointments with psychiatry and general practitioners, medication administration/observation and facilitation and encouragement to attend scheduled injection clinic and laboratory testing appointments. If clients decide not to take their medication, the ACT
team continues to work with that individual in other ways, and organizes individual counselling sessions to provide education, outline risks and offer medication support if needed.

Given the important role medication serves in mental health, it is crucial that the mental health team is knowledgeable and well educated in pharmacology. Due to my limited knowledge in this area, I spent considerable time researching commonly used medications by the mental health population. Consulting with psychiatry, attending psychiatric appointments with clients, and participating in discussions regarding client’s personal concerns and responses towards their medication regimes were all experiences that contributed to my working knowledge of medications.

With a clearer understanding of the process of pharmacology for the mental health population, I aided in supporting ACT clients in managing their medication by completing medication observations in the community, assisting in medication administrations when required, and by also providing education and support to clients to assist in their ability to identify and manage medication side effects. Strategies were also explored with clients to learn new coping skills and to reduce side effects of medication to support the journey of recovery and to assist in establishing a better quality of life.

6.3 Recreation

Available research suggests that recreation promotes recovery for individuals with mental illnesses (Fenton et al., 2016). The ACT model supports this philosophy, making sure to include recreation and leisure time activities in all ACT participant treatment plans. According to Fenton et al. (2016), recreation is considered “the experience that results from freely chosen participation in physical, social, intellectual, creative and spiritual pursuits that enhance individual and community wellbeing” (p. 348). Through the involvement of meaningful
activities and sport, individuals with mental illness experience many positive impacts. The recovery framework emphasizes that recreation not only assists with managing symptoms, but also provides opportunities for individuals with SMI to develop their social network and maintain social and interpersonal relationships, both essential components included in the process of recovery (Phillips & Burns, 2003). Staal and Jespersen (2015) make note of evidence that also suggests that many forms of sport, physical and social recreation, have a positive impact on both the mental and physical health of individuals (Staal & Jespersen, 2015). Physical recreation has been proven to alleviate symptoms of depression and anxiety, reduce body weight, improve cardiovascular health, and reduce various symptoms associated with mental illness (Fenton et al., 2016). It is argued that recreation may improve general health, physical functioning and quality of life (Staal & Jespersen, 2015).

Community recreation, in particular, promotes recovery and social inclusion (Fenton et al., 2016). Beneficial community recreation programs are described as spaces where the person is not identified as a client, and is provided with the opportunity to engage in meaningful activities, in the presence of supportive others (Fenton et al., 2016). Fenton et al. (2016) contends that “it is not simply engaging in a recreation activity that contributes to a meaningful life, but that it is the meanings that are negotiated and associated with the activities that have the most impact” (p. 349). Fenton et al. (2016) also contends that through community recreation, individuals gain an improved sense of belonging and a sense of community. It is argued that when individuals are given the chance to experience enjoyable and meaningful leisure activities, their recovery may very well be strengthened (Fenton et al., 2016). Social connections, the opportunity to develop social skills and expand social networks are all benefits of community recreation that also help to promote social inclusion (Fenton et al., 2016).
Fenton et al. (2016) argue that many mental health professionals undervalue how recreation activities can contribute to recovery for individuals with mental illness. The ACT team, however, highlights the significance of recreation in treatment planning on a regular basis. Throughout my practicum experience, the ACT team helped to facilitate many modes of intervention through recreation that emphasized recovery, as well as the strengths-based perspective. For instance, many participants of ACT experienced significant challenges leaving their home environment. Due to their mental illness, they often isolated and stopped participating in hobbies and past-times that they previously enjoyed. After fostering relationships with the ACT staff, I learned of the many interests that each client had. Horticulture, cooking classes and sporting activities are just a few examples of the recreation activities we were able to connect our clients to. Not only did these opportunities provide my clients with the opportunity to build on their strengths, but they also helped minimize concerns of isolation, increased physical health and assisted them in developing stronger social skills.

As a practicum student, I worked alongside the recreation therapist in planning and organizing several ACT events. On a weekly basis, I attended Calgary Talisman Centre and participated in basketball and badminton games with ACT clients. Monthly picnics and various outings including a day trip to the Calgary Stampede and Callaway Park, movie nights and a weekend of camping are examples of recreational activities that I participated in during my practicum experience. Moreover, I participated in additional community based recreation activities including monthly music therapy class and weekly coffee groups. A variety of diverse activities were offered by the ACT program, to create broad opportunities and satisfy the interests of everyone. Clients were given an option in terms of what activities they chose to participate in, but were expected to attend a minimum of one per week to promote the
importance of recreation and encourage socialization. This allowed individuals to make their own decisions about what they did, and did not, want to be involved in, promoting self-determination and encouraging independence to determine personal treatment plans.

Spending time in these social spaces provided me with insight into the importance of recreation. Through my observations and many conversations with ACT participants, I recognized the personal fulfillment and empowerment that was achieved through these social situations. I observed several clients create social connections with one another and share similar interests and commonalities. I observed that individuals genuinely looked forward to events and expressed excitement about spending time with one another. As a student, these recreational opportunities also strengthened my relationship with several clients. The opportunities allowed us to establish an equal ground and spend time with one another, on a more informal basis. Most importantly, these social spaces allowed individuals to enjoy their personal time with others, on a more equal level, and for just a short time, they were not defined by their illness.

6.4 Barriers to Recreation

While there are many benefits of participation in recreation activities for people with mental illness, it is also important to acknowledge the many barriers that prevent individuals with severe mental illness from engaging in recreation activities and partaking in the community. For many of those with SMI, symptoms of the mental illness, such as extreme fatigue, anxiety, depression or lack of motivation, discomfort in large crowds and so on, can all be factors that impact one’s ability to participate (Fenton et al., 2016). Environmental, financial and social barriers also restrict individuals from participating, as many people with SMI do not have access to transportation or the financial means to engage in community recreation (Fenton et al., 2016).
Community programs such as assertive community treatment are dedicated to eliminating and minimizing the barriers faced by the SMI population. Transportation and expenses for all recreational activities were supplied by the program. The staff, as well as myself, accompanied clients who expressed discomfort or required additional encouragement in attending activities. As mentioned previously, the importance of relationship building with clients is essential in their recovery. Many clients expressed enjoyment in attending recreation activities with ACT staff. Not only was it enjoyable for clients, but it also encouraged regular attendance and helped to establish routine, and both are essential elements of recovery.

6.5 Music Therapy

Music Therapy is a commonly used psychosocial intervention for the treatment of severe and persistent mental illness (Grocke, Bloch & Castle, 2008). Grocke, Bloch and Castle (2008) state that music therapy is a treatment strategy that assists in maintaining personal health and well-being. Musical therapy can support and address various needs of individuals, including physical, emotional psychological cognitive and social needs (Grocke, Block & Castle, 2008).

This type of therapy also contributes to several of the aspects found central for a person’s recovery. Through the strengths-based framework, music therapists identify strengths and empower individuals. Researchers have found that music therapy can be a positive treatment strategy for the mental health population, but specifically, for people diagnosed with schizophrenia or for people having an acute psychotic episode (Silverman & Leonard, 2012).

Solli and Rolvsjord (2015) completed a study in which the findings identified that music therapy is greatly valued by clients and has positive impacts on life circumstances and health in several ways. The study identified that clients considered music therapy to be engaging, motivating and enjoyable (Solli & Rolvsjord, 2015). Solli and Rolvsjord (2015) indicated that
participants also reported that music therapy made them feel “vital, uplifted, joyful, hopeful and motivated, and enabled them to become more active participants in their everyday lives” (p. 83). Several participants of this study revealed they did not consider music therapy to be a treatment, but more of an escape from illness, stigma and treatment (Solli & Rolvsjord, 2015). Several other outcome studies have found that music therapy improves mental health symptoms, increases confidence and self-esteem, promotes active participation, inclusiveness and shared leadership (Jackson, 2015). According to Silverman and Leonard (2012), music therapy improves symptoms and functioning of people, and provides meaningful roles for each participant.

The music therapy program was offered monthly at ACT. Prior to my practicum, I had not partaken in this type of therapy. During my first session, I was interested to see how many individuals attended the group, and participated in the programming. The pleasure and the happiness exhibited by the participants was the most rewarding moment for myself personally. At one point, I observed a client with schizophrenia singing along with the group. This was a powerful moment, as I had never observed this client to express himself through smiling, and he was usually only verbal when responding to internal stimuli, or in other words, the voices he heard due to his illness. However, this session of music therapy provided him a safe space to smile and sing along to the lyrics of the song. In this moment, I understood the importance of music therapy as a psychosocial intervention. For people with SMI, music therapy provides an opportunity to escape from the debilitating symptoms of mental illness. Moreover, this was a treatment strategy that people looked forward to that encouraged friendship, laughter and common ground, all very much needed experiences that mental illness tends to overshadow.
6.6 Coordination of Care and Liaising Between Services

Coordinating the care that clients receive, both from within the team and from other agencies is a key responsibility in the assertive community treatment model (Burns & Guest, 1999). In addition to mental health agencies and support services, ACT teams are also responsible for directly managing the finances of clients, assisting with budgeting, organizing appointee-ships, as well as several other tasks.

During my practicum, I assisted some clients in filing their income tax. While this may seem like a mundane task, for the mentally ill population keeping up with their income tax can be challenging, especially when suffering from an unpredictable and debilitating illness. The penalties for not filing your income tax can be substantial, as this can lead to further financial stress and burden for an already vulnerable population. In helping my clients with everyday tasks (such as income tax assistance) I felt that my relationships with these individuals strengthened considerably. I felt that my clients established a sense of trust in our working relationship, even though we had only known each other for a short time. Although this task was not directly related to their mental health, I recognize the importance of this service, as it improved quality of life for my clients and brought them happiness.

Liaising with health services and providing any support required is also a responsibility provided by ACT. As a student social worker, I assisted several clients in making medical appointments, connecting with addictions services and accompanied and advocated for clients during housing intake appointments.

What I appreciate the most about ACT is that the services offered by this program are flexible, and based on individual needs. There is no specific agenda when it comes to ACT treatment. I realized how supportive the ACT team really was when one of our clients was
diagnosed with a life-threatening illness. Immediately upon learning this information, our team called a meeting to determine how best to support our client in such a time of crisis. A schedule was made to ensure the client had transportation to and from all medical appointments, and to also ensure that the client was emotionally supported during this process. This was an eye opener for me early in the practicum; I realized that ACT truly cares about their clients. Community treatment is flexible, and our role is to support our clients in many ways, as life can be unpredictable for everyone and crises may arise.
Chapter 7: Ethical Practice in Mental Health Service Delivery

Ethical practice is a critical component in professions that are rooted in human service delivery. Social work upholds ethical practice as the utmost highest standard. This chapter will review the importance of ethical practice, as well as the challenges of ethical practice with the SMI population. Furthermore, my personal challenges experienced during the practicum in relation to ethical practice will be shared in this section.

Alberta Health Services is committed to promoting an ethical culture (Alberta Health Services [AHS], 2014). AHS Ethics Framework (2014) states that “building the organizations ethics capacity, providing support to those making decisions and faced with challenging ethics issues, and most importantly ensuring that we deliver health care and provide services with the highest ethical standards, is essential” (p. 2). For the ACT program, safeguarding the ethics of individuals with severe mental illness is a main priority, given the many vulnerabilities faced by individuals with SMI.

Although ethical practice is a main priority, there are several challenges that arise regarding ethics and the mental health population. A common ethical dilemma discussed in the research of ACT is the ethical balance between engagement and harassment (Claassen & Priebe, 2007). Considering most of ACT clients do not wish to be involved in psychiatric services, assertive outreach is a treatment strategy vital in achieving active participation from ACT clients (Phillips & Burns, 2003). Assertive outreach often includes impromptu home visits, frequent phone calls, and sometimes searching for clients in their regular community settings (Phillips & Burns, 2003). If the client is considered at risk of relapse, visits made by the community mental health team are often uninvited (Claassen & Priebe, 2007). In the ACT model, it is also common for visits to be continued, even when the individual declines further involvement. This type of
persistence, however, can present some controversy regarding the ethical rights of clients, as assertive outreach is intended to promote independence in a non-engaging individual, while also imposing mental health services when the client may not consent for further service. Some may argue that assertive outreach impedes clients’ rights to privacy and self-determination (Claassen & Priebe, 2007).

For the profession of social work, practicing in an ethical manner is of utmost importance. Upholding each person’s right to self-determination is a principle outlined in the CASW Code of Ethics (2005) that I continue to value in my practice as a social worker. This principle, however, was not limited to social work, and I observed the assertive community treatment team to all respect this principle within their practice throughout my time at ACT. Regarding the ethical concerns mentioned above, I did not personally come across this dilemma during my practicum. While it is possible to assume this could be a potential ethical concern in some assertive community treatment programs, ACT Calgary works conscientiously to foster positive relationships with their clients. Many of the clients I met during my time at the program had been participating in the program over the course of many years, and therefore, a strong sense of trust and partnership had been established. Nevertheless, without established relationships and with a lack of engagement and mistrust, it is expected that the ethical rights of clients may be called into question, especially during the process of engaging new clients (Claassen & Priebe, 2007).

Boundaries between clients and the mental health team can also be problematic when implementing the assertive community treatment model of service delivery. ACT practitioners spend an extensive amount of time with their clients, spending time in their homes, assisting with activities of daily living, joining clients in recreation activities and so on. By offering this type of
intensive contact, most clients report feeling encouraged, listened to and ultimately cared about (Appelbaum & Le Melle, 2008). While this type of therapeutic alliance is a vital component of the treatment process, it is also important to be aware of possible ethical concerns that may arise with such strong relationships between clients and staff members (Appelbaum & Le Melle, 2008). For instance, Burns and Guest (1999) warn that this type of intensive contact can complicate boundaries, as the relationship that has developed between the client and professional may hold qualities of friendship from the client’s perspective (Burns & Guest, 1999). If boundaries between the client and care provider have been violated, the integrity of the relationship and the treatment process are easily compromised (Burns & Guest, 1999).

My professional boundaries were tested on several occasions while working with one client specifically. This client was new to the program, and was not familiar with the ACT model. Working in less structured environments is a common practice in community treatment, and at the beginning of the intervention, to engage the client, I planned meetings and formulated treatment activities that were social in nature, which included going for coffee, going for a walk in the park and so on. Although on the surface these activities appeared to be social in nature, I made certain that a therapeutic purpose guided my interactions with the client. However, my client was unfamiliar with community based treatment and his behavior suggested that he misunderstood or did not understand the importance of professional boundaries.

For example, during scheduled meeting times, the client would refuse to discuss information regarding his mental health and would spend most of the time inquiring about my personal life. He would also call the case manager’s phone consistently throughout the day, without valid reason to call. This presented several challenges, but I addressed this issue by communicating my concerns with the client, and applying more appropriate boundary guidelines.
The therapeutic intent of activities was revisited with the client, as well as my professional role and involvement with the client. I did observe this to cause some conflicts in our relationship, as the client expressed hurt feelings, questioning whether I liked him on a personal level. While I recognize that his mental illness did contribute to some of the challenges he experienced in terms of his boundaries, through the practice of self-awareness I also recognized that I should have been clearer in my communication regarding professional boundaries and my role as a student in the program.
Chapter 8: Conclusion

The conclusion of this report will entail an account of my personal reflections and challenges during my involvement with ACT and the role of social work with persistent and severe mental illness. As a final point, this report will conclude with my future vision as a social worker. A closing summary will also be provided.

8.1 Personal Reflection and Challenges

Upon reflection, I have identified several challenges that I experienced during my time at assertive community treatment. When I first started my practicum, I felt self-assured that I would be a benefit to the mental health team. I have always identified as an anti-oppressive, strengths-based social worker, and I recognize the importance of this practice. However, after my first week at ACT, I felt somewhat unsettled and, for a moment, I questioned my ability to provide supportive and anti-oppressive social work practice. Regrettably and inadvertently, I found myself “giving in” to the stigmas and stereotypes associated with mental illness. I began the first day of the practicum reviewing health record charts to become familiar with the clients that I would be working with. The health record information included records of numerous suicide attempts, homicidal behaviors, committed crimes and sexual assaults, and trends of hostility, violence and aggressiveness. Although, prior to the chart review, I understood and anticipated complexities and significant social issues associated with mental illness, reading this information first-hand evoked personal feelings of fear and apprehension. To be honest, I was finding it difficult to stay positive and identify personal strengths. Truthfully, I was not convinced that successful recovery was even possible for some of my ACT clients. Given that anti-oppressive practice is an expectation and a strength of the social work discipline, I felt confused and
disappointed in how I was feeling, and worried that I would not be able to offer the type of service and support I had hoped I would be able to offer.

As I began to develop relationships with clients and cultivate an improved understanding of SMI, I started to observe the many strengths and achievements of the participants of ACT. Through ongoing support and mentorship from my ACT team, as well as from my time spent with clients, I learned that recovery is multifaceted, and an individual experience; recovery looks different for everyone. The information I obtained during my initial chart reviews helped me to eventually see how far my clients had progressed. Through continued learning, working outside of my comfort zone and committing myself to anti-oppressive practice, I soon began to understand that my clients were not people who were dangerous or violent, rather, they were strong, resilient and capable individuals.

The values, philosophies and frameworks that guide ACT were influential in helping me to practice anti-oppressive social work. The process of identifying my prejudicial attitudes and going through this experience led to an increased personal understanding of the presented power imbalances in my role on the assertive community treatment team. These types of imbalances will follow me in my career as a social worker, and it was important that I come to fully understand this. Larson (2008) contends that anti-oppressive practice “is much more than simply adopting a set of behaviors or skills that are congruent with this particular paradigm. It involves an awareness of the social worker’s location and how this can contribute to the oppressiveness of the intervention through classism, racism, ableism, heterosexism, and other ways that all of us as human being unfairly judge, rank and deal with others” (p. 48).
8.2 Role of Social Work

In witnessing the challenges experienced by ACT participants first hand, I understand even more clearly the importance of the role of the social worker in mental health service delivery. Social work, with its conceptual frameworks and value base of client focused treatment, has an opportunity to provide leadership in this area. Social work is responsible for the empowerment of clients and supporting autonomous and individual treatment strategies. Within the ACT model specifically, social workers are helping to minimize barriers and the burdens of mental illness by providing an array of services to clients with serious mental illness. Through advocacy, individualized treatment, focusing on client’s strengths, emphasizing hope, offering a range of comprehensive services and by providing continuity of care, ACT social workers have an influential role in facilitating the rehabilitation of people with SMI.

8.3 Future Vision

Completing my field practicum at Assertive Community Treatment was an exceptional experience. Although I was initially hesitant to relocate to another province and connect to an area of social work with only limited professional experience, I most definitely gained the educational challenges and experiences that I was looking for. Working at ACT has strengthened my skills as a social worker, and provided me with a new skill set and perspective. The knowledge that I have acquired regarding severe mental illness, the complexities associated with mental illness, and effective treatment strategies for severe mental illness is all useful information that I can implement into my current practice. This practicum has also allowed me the opportunity to expand my future career opportunities as well. While, prior to my practicum I felt satisfied in my current career, this experience has directed my interest towards social work
careers in mental health service delivery and this is a goal I hope to pursue very shortly upon completing my education.

8.4 Closing

This practicum served as an enriching educational experience and an invaluable experience on a personal and professional level. During my practicum, I learned about the effectiveness of community treatment for people suffering from mental illness. However, I was also reminded of the struggles and challenges experienced by this population, due to the public’s perception of mental illness. Sadly, whether intentional or not, our society continues to contribute to the exclusion and segregation of the SMI population through a combination of miseducation, lack of knowledge and discriminatory behavior. This type of societal stigma makes it very difficult for people suffering with mental illness to succeed. Stigma is tremendously powerful, as it impedes recovery, perpetuates discrimination and essentially results in barriers to employment, education, housing and so on.

Mental illness is a complex issue that involves many diagnoses, treatments and services, but even with its complexities, recovery from mental illness is very much possible. The assertive community treatment model, when adhered to closely, increases the likelihood of a successful recovery for people suffering with severe mental illness. While each discipline within the ACT team is important, the role of social work is substantial. Overall, this experience was invaluable and I look forward to applying the skills and knowledge that I have learned during my practicum towards my future social work practice.
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