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Institutional Analysis of Integrated Treatment for Co-Occurring Mental Health, Substance Use and Gambling Problems in Ontario: A Case Study

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INSTITUTIONAL ANALYSIS OF INTEGRATED TREATMENT FOR CO-OCCURRING MENTAL HEALTH, SUBSTANCE USE AND GAMBLING PROBLEMS IN ONTARIO: A CASE STUDY

BY

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Abstract

This dissertation explores the institutionalized response of the mental health and addiction sectors in Ontario to the pervasive demand for integrated services for people with concurrent disorders. Building on neo-institutional theory, I argue that despite the fact that different stakeholders on multiple levels - provincial governments, service providers, and clients - have called for the integration of treatment for concurrent disorders, this integrated treatment is implemented as a rationalized myth and adopted only ceremonially.

This is demonstrated through a case study of two treatment programs that provide services to populations with concurrent mental health and substance use problems and gambling problems. Both programs are organized as part of the Centre for Addiction and Mental Health in Toronto.

My findings address both macro- and micro-level foundations of the institutionalization of integrated practices. I have identified four key factors in the process of establishing integrated treatment for concurrent disorders as a standard practice. First, changes in public perceptions of mental health, substance use and gambling problems are associated with subsequent shifts in federal and provincial policies and mandates. Second, the need to conform to the public's expectation for more cost-effective services has brought challenges in providing comprehensive client-centered care. These challenges are exacerbated by the increased reliance on technically-driven cost efficiency when

planning treatment outcomes. Third, on the micro level, the endorsement of evidence-based practices is mutually related to internal structuring and specialization of care. Lastly, the institutionalization of integrated treatment is associated with individual involvement by social actors and their pursuit of personal and professional interests.

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I also want to thank Wayne Skinner from the Centre for Addiction and Mental Health in Toronto, who spent many hours helping me shape this study, respecting my own ways of learning and progressing with the topic. In addition, I want to acknowledge the input of researchers, program managers, clinicians, and service users who offered their time to participate in this research study.

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Table of Contents

Chapter 1:

Introduction

This dissertation explores the institutionalized response of the mental health and addiction sectors in Ontario to the pervasive demand for integrated services for people with concurrent disorders. Building on neo-institutional theory (DiMaggio & Powell, 1983/1991; Meyer & Rowan, 1977/1991), I argue that despite the fact that the call for integrated treatment for concurrent disorders has been raised by different levels of government, service providers and service users, integrated treatment for people with concurrent disorders continues to be implemented as a rationalized myth and is adopted only ceremonially.

This is demonstrated by analyzing a case study of two treatment programs that provide services to populations with concurrent disorders and gambling problems. The programs are an organizational part of the Center for Addiction and Mental Health in Toronto (CAMH), the largest provider of specialized mental health and addiction services in the province of Ontario, and also a PAHO/WHO collaborating centre.

The data was collected through interviews with individuals involved in the research, planning and delivery of services for people with concurrent disorders and gambling as well as service users and their family members. The analysis of relevant policy and organizational documents and excerpts from field notes were also used.

I argue that divergent ideological, political, and professional aspects of the broader institutional context are interrelated in both cases to the

institutionalization of integrated treatment for concurrent disorders. I have identified key factors relating to the process of establishing integrated treatment for concurrent disorders as a normative practice in these contexts. First, the changes in public perceptions of mental health and addiction, including problem gambling, lead to subsequent shifts in federal and provincial policies and mandates. Second, both cases have had to become isomorphic within changing institutional environments in order to survive. Related to these changes, the programs have experienced challenges arising from their attempts to keep the balance between comprehensive, client-centered care and the increased emphasis on technically driven cost efficiency. On the micro- level, institutional processes have been driven by the individual involvement of social actors in their pursuit of personal and professional interests. Accordingly, programs have undergone the process of internal restructuring and specialization reinforced by the emergence of evidence-based practices. Close adherence to empirically-based models of treatment for concurrent disorders has helped to increase the legitimacy of the studied programs.

CAMH, although itself representing the concept of integration by merging four mental health and addiction services - the Addiction Research Foundation (ARF), the Clarke Institute of Psychiatry, Queen Street Mental Health Centre and the Donwood Institute – still experiences the problems that mirror those present in both systems. Efforts to rationalize the health care system in the 1990s drew the attention of policy planners and service providers to the notion of integration on multiple levels and has been embraced as a template for the successful

delivery of the services. Integration of administrative structures, however, does not necessarily promote integrated practices on the clinical level.

The specialized Concurrent Disorders Service operating within CAMH became the closest to an integrated model of service; however, integrated treatment is still provided within disconnected, compartmentalized organizational and systemic structures, suggesting a merely ceremonial adoption of integrated treatment. High demand for integrated treatment provided by the Concurrent Disorders Service indicates that the program itself and its clinics have filled the gap for such services in the community. At the same time these services have minimal capacity because they remain underfunded.

In the case of problem gambling, my findings show that the institutionalization of the concept of concurrent disorders and integrated treatment in the provincial substance abuse sector has been related to an increased focus on co-occurring problem gambling, substance use and mental health problems. High rates of comorbidity among problem gamblers have been used as the rationale for developing comprehensive treatment for problem gamblers and these changes, originated in the substance use field, were mimicked or translated into the gambling sector.

The call for integrating treatment for problem gambling and other mental health problems has not received the same attention as it has in cases of concurrent mental health and substance use problems. This can be related to the under-utilization of problem gambling treatment in Ontario.

It is important for all participating parties – policy makers, service planners, services providers, and also service users - to engage in open discussion on the rationales for changes in the organization of treatment for concurrent disorders. It is also necessary to acknowledge the importance of ideological, organizational, and professional realms of institutional processes of integrated treatment. The aim of this thesis is to contribute to such a discussion.

1.1 Definition of the Problem

Co-occurring mental health and substance use problems have become an increasingly debated topic within the Canadian health and social systems (Health Canada, 2001). Over the last twenty years, concerns about concurrent disorders have been fuelled by research demonstrating the high overlap of these disorders both in the general population and in clinical samples (Drake & Mueser, 2000; Health Canada, 2001; Minkoff, 2001; Kolla, Marsh, & Erickson, 2006; Puddicombe, Rush, & Bois, 2004; Ross, Lin, & Cunningham, 1999). At the same time, evidence showing an association with problem gambling and increased rates of substance use and mental health problems has emerged in more recent American and Canadian studies (Hodgins, Peden, & Cassidy, 2005; Rush, Bassani, Urbanoski, & Castel, 2008; Shaffer & Korn, 2002). Consequently, problem gamblers have been identified as a population in need of comprehensive treatment services that address the complexities of their problems concurrently (Collins, Skinner, & Tonneato, 2006; Crockford & el-Guebly 1998; Korman, 2005; Korman, Collins, McCain, & Skinner, 2006;

Macallum & Blaszczynski, 2002; Shaffer & Korn, 2002; Wiebe, Cox, & Fallowski-Ham, 2003; Wiebe, Single, & Falkowski-Ham, 2003). The inadequate response to the needs of service users with complex problems has clearly identified the need to develop more effective clinical practices.

The development and implementation of effective treatment responses has therefore become a vital concern for various stakeholders responsible for planning, funding, and coordinating mental health and addiction services on both the national and provincial level (Health Canada, 2001; Hilarski & Wodarski, 2001; Kimberley & Osmond, 2003; Minkoff, 2001).

1.2 Rationale for the Study

In general, the rationale presented for integrated treatment is based on clinical studies indicating that the mental health and addiction treatment systems must accommodate a large number of clients with concurrent disorders. Not only are the treatments for these clients potentially more intensive, but it has also been claimed that in addition to its size, this client population is heterogeneous as a result of the various interactions between addiction and mental health problems (Health Canada, 2001; Hendrickson, 2006).

Accumulated problems and lack of adequate care are reflected in the deterioration of overall health for this population and its more frequent use of emergency care. Although clinical studies play an important role in advancing the quality of treatment of concurrent disorders – specifically co-occurring problem gambling, mental health and substance use problems (Drake, Mercer-

McFadden, Mueser, McHugo, & Bond, 1998; Drake & Mueser, 2000; Hodgins, Peden & Cassidy, 2005; Tonneato & Ladouceur, 2003; Toneatto, Skinner & Dragonetti, 2002) - significantly less attention has been paid to the organizational factors necessary for the development of integrated treatment. These factors include economic and administrative pressures, anticipated efficiency levels and quality of care, a stronger consumer movement and professional lobbying, competing treatment and support models as well as other contextual factors. Also, on the micro level, the relationships between and among policies, organizations, and individuals shape treatment ideologies and influence clinician-client interaction. Therefore, it is important to study how individual programs operate within larger related systems to show how their actions are affected by informal cooperative agreements, competition, referral patterns, funding flows, contracts, and other superior units (D'Aunno, Sutton, & Price, 1991; Scott & Black, 1986).

Chapter Summaries

To provide a context for this study, I will review the organization of the mental health, addiction and problem gambling services in Ontario in Chapter 2. I will briefly review literature examining how mental health problems, substance use, and problem gambling have evolved from being considered bizarre behaviours or personal vices, to social deviance, and later to medical diagnosis (Eaton, 2001; Horwitz & Scheid, 1999; Mechanic, 1991).

Although the disease model of addiction and problem gambling provided for the more humane treatment of this population (Polak, 2000), the model itself is deeply rooted in morality and constructs an individual as a pathological subject. The Diagnostic and Statistical Manual of the American Psychiatric Association has had an enormous role in the institutionalization of mental health, substance use and gambling problems; it has helped to legitimize the client's right for services in a large community of medical and non-medical professionals, including social workers. On the other hand, the medical model has been criticized for viewing clients as a "problem" themselves and for failing to attend to social-structural factors that lead to the oppression and marginalization of these clients (Csiernik, 2003a; 2003b; Csiernik & Rowe, 2003). Medical concepts of mental health and addiction have been used throughout history to defend oppressive practices from slavery to a lack of womens' rights to the demoralization of homosexual people (Bentley & Taylor, 2002).

The medical model also subjects these clients to treatment interventions they have limited control over and does not consider their autonomy and right to self-determination. The recent developments in the neurobiology of addiction, however, support the desire of medical professionals to re-medicalize traditional addiction treatment approaches that historically relied on verbal psychotherapeutic and educational interventions (O'Connell, 2002). The slow dissemination of empirically based psycho-social interventions into medically informed treatment of mental health problems has allowed psychiatric models to

dominate this field with the support of pharmacological treatments (Bentley & Taylor, 2002).

Problem gambling has had a distinctive evolutionary process as a result of recent changes in the perception of gambling as a leisure activity (Cosgrave & Klassen, 2001; Hargreave & Csiernik, 2003; McMillen, 1996). The treatment of problem gambling has been informed by the constructs of behavioral addictions and it has formally become part of the addiction system in Ontario. To better understand the association between gambling and co-occurring mental health and substance use problems, I reviewed the pathways model (Blaszczynski & Nower, 2002; Nower & Blaszczynski, 2004). The pathways model, used in one of the studied treatment programs to be discussed in detail below, focuses on the different levels of vulnerability for an individual who develops problems in his or her gambling behavior, and therefore identifies the heterogeneity of different subtypes of problem gamblers.

Applying the social work perspective to the organization of treatment of concurrent disorders and problem gambling, I utilized the argument of Yeheskel Hasenfeld (1971; 1972; 1985; 1992a, 1992b, 2000a; 2000b), who states that race, class, and gender contribute to the assignment of social value to clients of human service organizations. Individuals with concurrent disorders are stigmatized not only for their mental health and substance use conditions, but also because they do not respond well to traditional treatment. They are therefore perceived as a burden to both mental health and addiction treatment systems (Health Canada, 2001; Minkoff, 1997; 2001).

Historically, services for individuals with concurrent disorders have been provided separately and were often conducted by two different programs, organizations, or systems without sufficient coordination of care. As a result, traditional non-integrated treatment models have been widely criticized for poor treatment outcomes (Health Canada, 2001; Kimberley & Osmond, 2003). In contrast to this, integrated treatment has been generally accepted as the most appropriate treatment available since it applies aspects of both mental health and substance use problems to its treatment programs (Drake, Essock, Shaner, Carey, Minkoff, Kola,et al. 2001; Health Canada, 2001).

In Chapter 2, a review of mental health, substance use, and problem gambling within the medical model provides a backdrop for the theoretical orientation of this study. This will connect the reviewed literature on the organization of mental health, substance use, and problem gambling with the tenets of neo-institutional theory that will be used as the conceptual framework for this study.

The theoretical framework for this study will be provided in Chapter 3. Neo-institutional theory (DiMaggio & Powell, 1983/1991; Meyer & Rowan, 1977/1991), rooted in social constructivism (Berger & Luckman, 1980) provides this study with a framework that facilitates an examination of the interrelationship between broader institutional environment and micro-processes in the development and implementation of integrated treatment. The central premise from which I interpret this data is that organizations have to become isomorphic within their institutional environments in order to survive (Scott, 2001; 2008). Institutional

pressures on organizations to conform produce three mechanisms – coercive, normative, and mimetic isomorphism (DiMaggio & Powell, 1983/1991) – all of which I identified in the institutionalization of integrated treatment.

According to Meyer and Rowan (1977/1991), products, services, and policies function as powerful myths and organizations adopt them ceremonially to gain legitimacy in their institutional environments. A typical rationalized myth can be a practice or treatment model created and shared by organizations occupying the same institutional environment. The legitimacy of such a myth is based on its alleged efficacy or on the legal mandates imposed on organizations by different governing bodies. Once legitimized within its institutional environment, the superiority of integrated treatment became a commonly shared understanding and was thereafter taken for granted as a vital concept.

Recent developments in neo-institutional theory as it relates to organizational discourse provide a conceptual framework for the institutionalization of integrated treatment through the creation and dissemination of organizational language, texts, and symbols (Maguire & Hardy, 2006; Phillips, Lawrence, & Hardy, 2004). Texts and metaphors initiate organizational change as they are distributed throughout a group of organizations. Texts are interpreted through a process of "translation" of ideas; they shape and are shaped by individual constructs of reality by participating parties (Czarniawska & Joerges, 1996). The concept of translational organizational change assisted in the interpretation of micro- level processes of institutional changes that were initiated through the individual agency of leading professionals in this field.

Mental health and addiction services, belonging to human service organizations, have distinct features that have to be addressed when applying this conceptual framework. Hasenfeld (1992a; 2000a) emphasizes that human service organizations operate in highly unstable environments from which they must derive their legitimacy. Indeterminate technologies based on subjective knowledge and personal prerogatives bring another source of uncertainty to these environments. Adapting to these conditions requires formulating elaborate ideologies to accommodate ambiguous or even conflicting goals. The instability of the institutional environments for human service organizations is due to the development of moral judgments by these organizations, attributing different levels of social worth to clients' responsibility or amenability to change. The desired "final products" are the result of altering and transforming people's personal qualities (Hasenfeld, 1985; 1992a; 2000a). The programs in this study work with stigmatized populations whose social worth is drastically minimized by such moral judgments.

Following the Chapter 3 review of the conceptual framework, I will elaborate in Chapter 4 on the research methodology of the study, particularly the rationale behind my methodological choices. I have used a holistic, multiple case study design which has provided me with flexibility in case definition and in exploring the contextual factors of the cases (Yin, 2003b).

The two cases highlighted in this study and analyzed within a broader organizational context are as follows: the first program, the Concurrent Disorder Service, is mandated to provide specialized treatment for co-occurring mental

health and substance use problems; the second program, the Problem Gambling Service, is a specialized service for individuals with gambling problems. Although the second program is not profiled as a formal integrated service within CAMH, it does provide services to populations with complex needs. The comparative analysis of these programs explores how their clinical practices respond to the pressure of addressing the multiple problems of populations with concurrent mental health, substance use and gambling problems. I have designed my research on the premise that our perception of reality is highly subjective, and everyone can socially construct his or her own reality very differently (Berger & Luckman, 1980). I also concur with Lincoln and Guba (2000), who acknowledge the existence of created knowledge as dependent upon the interaction between the researcher and research participants. Organizational changes can be altered by the created knowledge of researcher and participant. The "multidimensional" and "interactive" nature of this interpretation, both subjective and selective (Maxwell, 2005; Patton, 2002), is the lens through which I view the data, which is then further enhanced by the conceptual framework outlined in Chapter 3.

The nature of this case study has provided the flexibility necessary for organizational research of this kind. I have adapted to the aspects of organizational research that were beyond my control, such as accessibility to the research site. This case study has also allowed me to include useful information on the dynamics of the research site in the analysis and thus provide a more comprehensive analysis of the data. The credibility or dependability of the data has been achieved by sharing my logical inferences and interpretations with

research participants and other independent parties to provide a regulating force for my conclusions (Lee, 1999; Marshall & Rossman, 2006).

In Chapter 5, I will present the broad institutional context of my two cases by providing a review of national and provincial mental health, addiction, and gambling policies. I will then examine how the development and implementation of integrated treatment for concurrent disorders has been interrelated with ideological, political, professional, and bureaucratic factors in both mental health and addiction sectors. The review of relevant policy documents in mental health and addiction sectors revealed that, in the 1980s, individuals with "dual diagnosis" were acknowledged as a vulnerable subpopulation that could be easily excluded from treatment; however, no specific measures were undertaken to address the problem. Diversifying clinical research by focusing on various subpopulations such as women, youth, and First Nations populations, brought more public attention to the needs of those who required specific, tailored services. Among the factors involved in recognizing concurrent disorders as a concept was the demand from people with these disorders for better services. At the same time, the acknowledgment of the organizational problems by clinical staff working in mental health and addiction services underscored the need to develop and provide more effective services for this population.

I will argue that the substantial change in the organization of mental health and addiction services in Ontario was related to the more general reorganization of the Ontario health care system, particularly with regard to the mandate of the Health Systems Restructuring Commission (HSRC) to rationalize the provincial

health system. Four different mental health and addiction organizations were amalgamated into the CAMH, which became vocal in promoting integrated treatment for concurrent disorders. In the new millennium, the establishment of Local Integrated Health Networks (LHINs) as part of the provincial health care reform echoes an existing rhetoric on systems integration, including the emphasis on simultaneous treatment for concurrent mental health and substance use problems accentuated by the evolution of CAMH.

In Chapter 6, I will attend to the institutionalization of integrated treatment for concurrent disorders through analyses of the two programs in my study: the Concurrent Disorders Service and the Problem Gambling Service. I will analyze the interrelationship between broader contextual factors and treatment environments in these two programs. I will demonstrate how the institutionalization of integrated treatment developed through discourses such as structured texts, symbols, and powerful metaphors. I will support this argument by analyzing the "texts" that became catalysts for the integration "movement" along with the analysis of powerful metaphors adopted from broader cultural rationalized myths such as integration in general leads to efficiency, and rationalization and better or innovative practices. I will argue that treatment ideologies, shaped by the personal and professional orientation of clinical staff, can provide an overarching framework for the mission and vision of the programs. Their adoption, however, can have only symbolic character. The internal structuring and specialization of services supports the argument that, in order to gain legitimacy in their changing institutional environment, both

treatment programs have engaged in a diversification of their services. During this process, individual agency, along with the personal preferences and professional backgrounds of clinicians, helped to define the treatment orientation of both programs.

Next, I will demonstrate how some of the adopted treatment approaches, recognized as evidence-based practices, gained greater legitimacy due to their adherence to technically driven efficiency of time-limited treatment. The clash between treatment efficiency and client-centered care informed by the professional prerogative of clinical staff will also be examined. I will conclude with data that indicates that the CAMH itself experiences similar obstacles that mirror the problems experienced in both systems as they pursue integrated service provisions.

In Chapter 7, I will discuss the findings presented within the frame of neo-institutional theory and the insights regarding the macro- and micro-processes within the institutionalization of integrated treatment for concurrent disorders that were uncovered in this study. Mental health, substance use, and problem gambling services in Ontario have experienced various changes prompted by political, ideological and economic factors. These changes have shaped the isomorphic adaptation of the two programs to their institutional environment. I will argue that the government mandate leading to the amalgamation of services at CAMH has been a strong impetus towards the institutionalization of integrated treatment. Part of the rationale for this mandate was the recognition of the existence of concurrent disorders, supported by population and clinical studies in

the United States and Canada (Drake, McLaughlin, Pepper, & Minkoff, 1991; Drake & Mueser, 2000; Health Canada, 2001; Kolla, Marsh, & Erickson, 2006; Minkoff, 1997; 2001; Mueser, Noordsy, Drake, & Fox, 2003; Ross, Glaser, & Germanson, 1988; Ross, Lin, & Cunningham, 1999; Substance Abuse and Mental Health Service Administration, 2002). Integration was perceived as a means by which the "silos" of mental health and addiction systems could be broken, leading to smoother cooperation between programs and services.

Further, I will critically analyze the ubiquity of the rationale for integration based on the superiority of integrated treatment over standard approaches (e.g. parallel and sequential treatment). I concur with Flynn and Brown (2008), Mueser, Noordsy, Drake and Fox (2003), and Drake, Mueser, Brunette, and McHugo (2004) that the severity of concurrent mental health and addiction problems as well as the diversity among populations with concurrent disorders have to be considered when advocating integrated practices as the most effective treatment.

Using the concept of organizational discourse and the institutionalization of integrated treatment, I will discuss how several texts and metaphors facilitate the institutionalization of integrated treatment. In this process, individual actors – researchers, clinical managers, and policy-makers – were instrumental in the translation and diffusion of organizational change. I will also discuss how the professional orientation and individual agency of these social actors led to specific forms of internal structuring and greater specialization of services in both programs. Similarly, this specialization has supported the development of

empirically-based methods that, in turn, increase the legitimacy of the programs themselves.

This thesis will conclude in Chapter 8 with a discussion of the contribution of this research towards continued discourse on concurrent disorders. I argue that this study helps us better understand the processes that have been closely associated with the development and implementation of integrated treatment. It provides an increased insight into the political and ideological realms of policy-making, service planning and service delivery. I will conclude this chapter with a discussion of the implications of this study for addiction services attempting to provide support for concurrent disorders and with an outline of the relevance of this study for social work practice

1.3 Terminology: Definition of Used Terms

The complicated nature of concurrent mental health and substance use disorders is evident from the complexity of the terminology that is used. For the purpose of this thesis, I will use the term "concurrent disorders" to represent a combination of mental and emotional or psychiatric problems with substance abuse problems that considers concurrent disorders as a plurality rather than a duality (Drake & Wallach, 2000; Health Canada, 2001). For diagnostic purposes, "concurrent disorders" refer to any combination of mental health and substance use disorders identified by using the diagnostic criteria from the Diagnostic and Statistical Manual for Mental Disorders (American Psychiatric Association, 2000).

The terms "dual diagnosis" or "dually diagnosed", which are also frequently used, lead to confusion because they also refer to those who have both mental health problems and are developmentally delayed, or those with mental health problems and a physical disability (Substance Abuse and Mental Health Services Administration, 2002). Drake and Wallach (2000) indicate that in the case of concurrent disorders, the term "dual diagnosis is an unfortunate misnomer" (p.1126), because this group of individuals is heterogeneous and tends to have multiple impairments rather than just two illnesses. Professional literature and clinical practice also use the terms "comorbidity" and "co-occurring disorders", "mentally ill chemical abuser" or "substance-abusing mentally ill" (Watkins, Lewellen, & Barrett, 2001). Although each term might be justified by the particular focus of the authors who use them, such a diversity of terminology complicates literature and fragments the development of a common body of knowledge of the studied phenomenon. In this dissertation, I will be using the term "concurrent mental health and substance use problems" or "concurrent mental health and addiction problems" when referring to both substance use and gambling problems. In Ontario, the Ministry of Health and Long-Term Care use the term "'concurrent disorders' to describe co-occurring addiction and mental health problems" (Skinner, 2005, p. xv).

"Compulsive gambling" (often called "pathological gambling" or "disordered gambling") entered the classification of mental disorders as an impulse control disorder (American Psychiatric Association, 1994; 2000), while "problem gambling" is characterized as extensive form of gambling with various

negative consequences in an individual's life, but lacking in the pathological, impulse-driven aspects of "pathological gambling" (Orford, 2001). The social work perspective understands problem gambling as an emerging issue that, apart from biological and behavioural factors, needs to be viewed as an economic and social phenomenon (Hargreave & Csiernik, 2003).

The criteria utilized for diagnosing pathological gambling – for example: tolerance, withdrawal, attempts to stop, and impairment in many areas of life functions - are almost identical to those used to identify substance use disorders or other forms of addictions (APA, 1994; 2000; Grant & Potenza, 2005). The distinctive factor of problem gambling is that after losing money, the gambler starts "chasing his or her losses" and engages in even more hazardous gambling behaviours (Blaczszynski & Nower, 2002). I will use the term "problem gambling" as it represents gambling behaviour beyond the social, non-problematic forms of gambling that does not stigmatize an individual. This term is based on the social work perspective on problem gambling (Hargreave & Csiernik, 2003).

Also, when referring to drug use, I use the term "addiction" as encompassing both psychological and physiological aspects of drug use. In this thesis, when using the term "addiction", I also refer to problem gambling, whereas the term "substance use problems" would only refer to the negative consequences of psychoactive drugs.

Chapter 2:

Literature Review

Introduction

The literature reviewed for this research study provides a substantive context to facilitate the interpretation of my findings and to identify gaps in existing research on integrated treatment for concurrent disorders. First, I review the literature that details how personal conceptualizations and definitions of mental health problems, substance abuse, and problem gambling influence the measures taken to address them. Second, I review mental health, addiction, and problem gambling services in Ontario.

The latter part of this chapter details the current organization of treatment for concurrent disorders. Notwithstanding the importance of research studies examining clinical issues and the efficacy of existing treatment approaches (Drake, et al., 1991; Drake, et al., 2001; Drake & Wallach, 2000), for the purpose of this study, I provide a review of some of the frameworks used in the organization of treatment for concurrent disorders. I then focus on research that investigated the organizational factors of treatment for concurrent disorders.

2.1 Perceptions of Mental Health, Substance Use and Gambling Problems

In Western society, among the different models used to understand mental health problems, the medical model has become predominant (Clarke, 2000; Eaton, 2001; Mechanic, 1999). The positive aspect of this model is that by providing an understanding of mental disorders as a disease with distinctive symptoms arising from a dysfunction in the individual, it has attempted to de-stigmatize and humanize treatment services for mental illness (Mechanic, 1999; Scheid, 2004).

Eaton (2001) describes the medical model of mental disorders as a framework for explaining exceptions to everyday normalities and for legitimizing the existence of institutional responses towards mental disorders. He further asserts that "institutions for identifying, processing, and resocializing deviants have, as their manifest function, the correction of the deviant behaviour of the individual" (Eaton, 2001; p. 27). The processes of identification, labelling, and correction of "deviants" helps define societal norms and creates solidarity among "non-deviants" in their attempts to separate and protect themselves. In this regard, an institutionalization of societal responses has taken the form of diagnostic tools such as the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA). The most fundamental change DSM experienced during its evolution was the replacement of classifications of dynamic psychiatry in the more symptom-based DSM-III (Eaton, 2001; Horwitz, 2002). Other important factors in the development of the disease model of

mental disorders and addiction include breakthroughs in brain imaging, moving psychiatry away from its psychodynamic and behavioural roots towards the neurobiological model, and advances in the development of new pharmaceuticals (Mechanic, 1999).

The understanding of addiction as a brain disease has had implications in the development of treatment; however, in the case of problem gambling, Turner (2005) challenges the notion of a biological basis, but admits that problem gambling has been "linked to some genes and to a dysfuntion of the reward system" (p. 5). Treatment programs for problem gamblers have derived from work done in the area of substance abuse and problem gambling has been treated as an addictive behaviour (Castellani, 2000; Grant & Potenza, 2005; Horwitz, 2002). According to O'Connell (2002) and Flanzer, Gorman and Spence (2001) developments in the neurobiology of addiction reflect the trend to re-medicalize traditional addiction treatment approaches. These developments attempt to reconceptualize verbal psychotherapeutic and educational interventions to accord with the newest medical research. Although the neurobiological model of mental health problems and addictions unite them within biological foundations, an individual with a mental disorder - unlike a person with drug use or gambling problems - is not considered responsible for his or her disorder. In the case of drug use, the leading research institute in the United States, the National Institute on Drug Abuse, asserts that drug use is a voluntary action only for the first couple of doses. However, subsequent

progression and continued usage is the result of a developed compulsive behaviour, which is then perceived as a disease (Vastag, 2001)

Polak (2000) claims that the disease model justified a more humane treatment approach to addiction that includes pharmacotherapy. The disease model however, does not account for the interplay between the individual characteristics of the user and the broader structural factors present in a society perpetuating the oppression and marginality of some of its members (Csiernik & Rowe, 2003). Although the growth of medical professionals specializing in addiction contributed to the social concept of substance use as a disease, Harding (1988) argues that what was proposed by medical professionals in the 19th and 20th century was in fact "a reformulated moral pathological model" (p. 57). Moral judgment is still a visible presence in public attitudes towards individuals with mental health and addiction problems. To exemplify this bias: "drug use should not have a place in a society that values action, rationality, and predictability... [a]ddicts, viewed as enslaved, unproductive, inefficient, and self-centered escapists are a threat to American society" (Kandall, 1996, p. 72).

Treatment Approaches to Addiction

From the social work perspective, substance use problems have a complex bio-psycho-social nature. The bio-psycho-social model acknowledges the diversity of individual problems that arise from the interaction of various factors present in the life of every individual. The holistic approach to assessment and treatment of addiction problems attempts to address the interrelationship between genetic inheritance, temperament, family, school, and community as

well as social and socio-economic factors in an ongoing interactive manner (Csiernik, 2003a; 2003b; DiClemente, 2003). This suggests a broader treatment perspective for addiction that addresses these phenomena as part of a complex problem.

In the case of problem gambling, as mentioned earlier, treatment has been informed by the constructs of behavioural addiction. The earlier developments to approaches for substance use problems, such as the Stages of Change Model (Prochaska & DiClemente, & Norcross, 1992) or Motivational Interviewing (Miller & Rollnick, 2002), have since become part of treatment interventions. Although problem gambling has become part of a more inclusive and complex concept of addiction, unlike the treatment of substance use problems or drug dependency, pharmacological treatment has not played a significant role in treatment of problem gambling. The result of studies in changes in dopaminergic and serotonergic brain functions among problem gamblers support the ongoing quest for effective pharmacotherapy and continued clinical research. However, so far no medication has been proven to reduce problem gambling nor has any medication been approved for its treatment

The strongest indications for using pharmacotherapy in the treatment of problem gambling is the existence of comorbidity factors such as depression, bipolar disorder, attention deficit hyperactivity disorder, and substance use problems (Rosenthal, 1998). The evidence for the use of medication to address mental health, substance use *and* problem gambling has been scarce, particularly in attempts to reduce the biological and psychological craving to

gamble.[1] The remaining obstacle in identifying effective pharmacotherapy for concurrent problem gambling and other co-occurring problems is the complex non-linear interrelationship between multiple mental health, substance use and gambling conditions (Kimberley & Osmond, 2003). Consequently, prevalent treatment approaches for problem gambling in Ontario have been informed by cognitive behavioural models rather than medical ones (Hargreave & Csiernik, 2003). The mutual support of Gamblers Anonymous remains the most frequent "intervention" and an important part of recovery process (Ferentzy, Skinner, & Antze, 2004).

The theoretical model that became one of the most influential approaches developed for the problem gambling population is the *pathways model* (Blaszczynski & Nower, 2002). The model is "predicated on the argument that the quest to impose one theoretical model to apply equally and validly to all pathological gamblers is a misguided venture"(Blaszczynski & Nower, 2002, p. 487). Instead, the pathways model attends to the heterogeneity of different subtypes of problem gamblers. Although there have been different models that attempt to explain problem gambling and indicate effective treatment - notably addiction (Jacobs, 1986), behavioural (McConaghy, Armstrong, Blaszczynski, & Allcock, 1983), and cognitive (Ladoucer & Walker, 1996) - Blaszczynski & Nower (2002) criticize the aforementioned models for their view of problem gamblers as a homogeneous population. In the pathways model, three distinct subgroups of gamblers are identified: a) behaviorally conditioned problem gamblers, b)

[1] For example the recent study of Toneatto, Brands, & Selby (2009) did not prove the efficacy of naltrexone for treatment of co-occurring alcohol use or dependence and problem gambling.

emotionally vulnerable problem gamblers, and c) antisocial, impulsive problem gamblers (Blaszczynski & Nower, 2002). This model integrates biological, personality, developmental, cognitive, behavioural, and environmental factors. All pathways share common processes, such as those learned and behavioural based on operant conditioning, and features, such as availability of gambling, that lead to habitual patterns of gambling behaviour. The progress of gambling behaviour is also accompanied by distorted thinking. As losses begin to accumulate, a person experiences pressure to extricate himself or herself from the dire financial situation. Blaszczynski & Nower (2002) characterize this as the point where gambling behaviour become problematic.

As Hasenfeld (1992a; 2000a) states, race, class, and gender contribute to the assignment of certain social values on clients of human service organizations and the simultaneous and subsequent societal response. In the case of addiction to illicit drugs, treatment has been heavily based upon the social interpretation of that behaviour. When drug users are acceptable members of mainstream society, their drug habit is more likely to be tolerated or addressed in a different way than among more socially marginalized ethnic groups (Cohen, 1990; Courtwright, 1982; Csiernik, 2003a; 2003b; Harding, 1988; Kandall, 1996; Musto, 1987; Peele, 1985; Zsazs, 1974; 2003). The development and expansion of the disease model in Canada and the United States has been related to large scale experimentation and drug use in the 1960s and 1970s by white middle-class youth and the emergence of problem gambling in the 1980s and 1990s after middle-class citizens engaged in gambling as a newly promoted

leisure activity (Acker, 2002; Bernhard & Preston, 2004; Castellani, 2000; Cosgrave & Klassen, 2001).

According to Dombrink (1996), another important factor in the development of medical responses to addiction was the lengthy prison sentences imposed for the possession of minor amounts of marijuana for children and youth of affluent middle-class families and, later on, the maturation of many users into the legal authorities themselves. On the other hand, the use of crack cocaine in the 1980s by mostly urban non-white populations, as opposed to the affluent white users of powder cocaine, generated harsher policy measures designed to tackle the "crack epidemic". Society has since become terrified by the "crack babies" phenomenon, which exaggerates the number of children born to crack-addicted women and the long term effects of drug use by expectant mothers (Ray & Ksir, 2004). As a result, drug control resonates against class-based and racial lines. The disproportionate number of African American and Hispanic minorities in the American prison system is evidence that drug policy in the United States is discriminatory towards racial minorities (Wachholz, 2000).

Social movements lobbying for the liberalization of penalties for the consumption of illegal drugs or associated crimes justify their activities as attempts to avoid public nuisance and by the very high expenditures on the never-ending "War on Drugs". Changing attitudes towards drug use is also supported by a public health perspective that emphasizes harm reduction policies, particularly the prevention of the spread of infectious diseases from vulnerable groups to the general public. The harm reduction model has become

closely associated with addiction interventions for the last twenty years, after recognizing that drug problems need to be addressed at the societal level and cannot depend merely on individual identification of addiction problems (Single, 2001; CAMH background paper on harm reduction, 2008).

The most basic form of harm reduction can be defined as any strategy or action that reduces the potential of existing harm associated with various human behaviours or acts (CAMH background paper on Harm Reduction, 2008; Haden, 2006; Hobden & Cunnigham, 2006; MacPherson, Mulla, & Richardson, 2006; Marsh & Fair, 2006; Single 1995; 1997; 1999; 2001; Watkin, Rowe, & Csiernik, 2003). Harm reduction in the CAMH position paper (2008) is defined as "any program or policy designed to reduce drug-related harm without requiring the cessation of drug use", clearly separating harm reduction from abstinence oriented models. At the same time, the more recent conceptualization of harm reduction includes abstinence (CAMH, 2008; Ministry of Health and Long Term Care [MoHLTC], 2009). Faupel, Horowitz, and Weaver (2004) report that although effectively implemented in Europe and Australia, harm reduction in the US only became formalized in the 1980s after the spread of haemotologically-borne infectious diseases such as hepatitis and HIV-AIDS among injection drug users. Harm reduction, initially providing sterile needles and syringes or syringe exchange and methadone maintenance to address illicit drug use, has become an overarching model for reducing risk in the use of more accepted legalized drugs such as alcohol and tobacco (e.g. moderate drinking) (Sobell, Cunningham, & Sobell, 1996; Sobell & Sobell, 1993; 2000).

In the context of Canadian drug policy precedents, the "Four Pillar" drug strategy, harm reduction, prevention, treatment, and law enforcement adopted in 2001 by the City of Vancouver has focused on balancing public health with public order as well as attempting to target the most marginalized groups associated with illicit drug use (MacPherson, 2004; MacPherson, et al., 2006; Marsh & Fair, 2006). The four tenets of this drug policy soon became an organizing principle for drug policies in other Canadian cities and provinces (Edmonton Community Drug Strategy, 2007; Regina & Area Drug Strategy, 2003; The Toronto Drug Strategy, 2005) as well as for other national initiatives (The National Framework for Action to Reduce the Harms Associated with Alcohol, Drugs and Other Substances, 2005). This integrated approach to substance use problems has unified stakeholders who recognize the drug problem as a complex issue fuelled by social and economic factors such as poverty, unemployment, lack of subsidized housing, and the marginalization of certain subpopulations. The harm reduction strategies, including the "Four Pillar" approach, remain highly politicized and controversial, particularly among recent Conservative governments that refuse to support it as a legitimate part of the national drug strategy. The last National Anti-Drug Strategy (2004) adopted by the federal Conservative government intentionally left out harm reduction in its policies. This deliberate shift from the drug policy adopted by the previous Liberal administration can, according to the CAMH position paper on The National Anti-Drug Strategy (September 2008), bring similar negative results as the American drug strategy has: namely, an increased number of individuals incarcerated for drug use and increased health-

related harm. This approach is in direct opposition with social work values that consider every individual to be unique and worthy, entitled to justice, freedom and to be part of the community (Watkin, Rowe, & Csiernik, 2003).

In gambling-related problems, the public health perspective[2] has also recently been employed, as suggested by Korn & Shaffer (1999) and Shaffer and Korn (2002). They recommend using the classic public health model for communicable disease with host, agent, environment, and vector as a basis for understanding the phenomenon of gambling-related problems (Korn & Shaffer, 1999; Shaffer & Korn, 2002).

The public health model can shed light on the multiple dimensions of gambling-related problems and suggest possible prevention and treatment options. However, Abbott (2005) indicates that the public health perspective toward problem gambling has been favourably received by gambling industries due to the emphasis on risk factors carried by the host - the individual that develops gambling problems due to various individual risks - rather than by the agent representing specific gambling activities: lotteries, slot machines, or the environment, and the socio-cultural, economic, or political context in which gambling occurs (Korn & Shaffer, 1999). Abbott (2005) further reports that historically there have been various attempts by the gambling industry to publicly discredit or dismiss studies that suggest a strong correlation between the industry's expansion and problem gambling.

[2] Although the public health model uses various terms such as "problem gambling", gambling-related problems" and "pathological gambling", I will refrain from using the term "pathological gambling" as this is not congruent with terminology adopted and used in Social Work practice.

The follow-up study of Wiebe, Single, and Falkowski-Ham (2003) reports that significant numbers of individuals who were identified as gamblers with moderate or high severity problems did not meet these same criteria after one year. These results, however, may be disputed based on the methodological constraints of the research design. Regardless, the economic strain of problem gambling on a relatively small number of people has adverse effects on their physical and mental health in addition to their social and personal lives (Williams & Wood, 2004). Although Blaszczynski, Ladouceur and Shaffer (2004) and Blaszczynski (2005) call for respecting the right of the individual to make informed choices, they also admit that this applies only to a healthy individual without any comorbid psychiatric disorders that would affect his or her cognitive processes. In this regard, Blaszczynski, Ladoucer and Shaffer (2004) outline the framework for responsible gambling and harm minimization activities. This framework would promote gambling prevention for vulnerable groups and communities and allow the gambling industry to deliver their "products" only for recreational purposes. These ideas complement the public choice model, reinforcing the political ideology of liberalism and economic growth that replaced the "legalization of deviance" model from the 1970s (McMillen, 1996). On the other hand, Dombrink (1996) reports the existence of alternative arguments for legal reforms for gambling and illegal drugs. Gambling has diverged from other vices because it has not produced as much cultural conflict and moral resentment because it lacks the physical damage and it is associated with white-collar crime.

Gambling as a revenue-generating activity with state-operated ownership and charity funding has not been the subject of re-criminalization sentiments as frequently as illegal drug concerns have. Moreover, it has been promoted and integrated into societies as a recreational activity (Hargreave & Csiernik, 2003; McMillen, 1996; Walker, 1996). Problem gambling, because of the prevailing perception that it brings about economic rather than physical harm for individuals, is not viewed as representing the same threat to society as alcohol or drug use (Dombrink, 1996). It has been observed that the legal reforms in gambling, drug, and alcohol use can easily become part of political agendas and therefore can be influenced by the size of constituencies and the power of other interested parties (Dombrink, 1996; Orford, 2005; Room, 2005). Accordingly, increased tax revenues receive more public support and therefore gambling, alcohol, and tobacco receive more public tolerance than illicit drug use.

Orford (2002) and Room (2005) point out similar consequences in the alcohol and gambling policies of the United Kingdom and how the government's support of permissive public policies towards greater accessibility of alcohol and gambling environments has resulted in a higher prevalence of alcohol abuse and problem gambling. Room, Turner and Ialomiteanu (1999) also found that, similar to cases of alcohol and drugs, the higher availability of gambling venues in Ontario has been linked to a higher prevalence of problem gambling. Swedish and Australian national prevalence studies also report findings that support this same availability theory (Ronnberg, 2005). Contrary to the studies of Room, Turner and Ialomiteanu (1999) and Orford (2005), Shaffer (2005) argues that

higher prevalence of problem gambling is observed only in recently legalized gambling settings, while in more mature gambling environments, such as Nevada, exposure has a less adverse effect and problematic forms of gambling are more likely to decrease over time. Although Shaffer (2005) illustrates his argument by drawing comparisons to alcohol and tobacco policies, the example is questionable because the decrease in alcohol and particularly tobacco consumption usually follows strict regulation policies (Skinner, personal communication, July 15, 2008).

2.2 Mental Health and Addiction Services in Ontario: Historical Perspective

Mental health and addiction systems in Canada have undergone two separate journeys in their attempt to design, develop, and provide services for people with mental health and addiction problems (Kirby, 2004a). Both delivery systems will be examined separately as this will allow for a later comparison while looking for parallels and differences that could lead to better understanding of the studied topic. I will also provide a review of gambling policies and the development of the above-mentioned mental health and addiction sectors particularly in relation to concurrent disorders.

Mental Health Services in Ontario

The mental health system in Ontario has evolved as a response to pressures from various powerful groups, advances in technology, population changes, and changes in social climate. Gold (1998) reports that the system has been subjected to poor planning processes and a haphazard implementation of developed policies. Denton (2000) assures that rather than planning process, health and social policies and services are closely related to the ideology of political establishment that has the mandate to govern. The following sections provide a review of the evolution of the Ontario mental health services in the broader national context.

Institutionalization (1900-1960)

Institutionalization's first phase, which spanned the late 1800s until the mid-1900s, relied heavily upon institutionalized care in mental hospitals. The development of "lunatic asylums" across North America and Europe during the 19th and 20th centuries allowed for an expansion of psychiatry through its professionalization as a medical discipline (Kirby, 2004a). The emphasis upon mental illness as the result of disease and damage to the brain to some extent freed people from the dominant views on mental health from 17th and 18th centuries as a self-inflicted condition acquired through an immoral lifestyle. However, this model did not bring respite for its sufferers because successful recovery was viewed only pessimistically (Kirby, 2004a).

During the era of institutionalization (1900-1960), psychiatry made an effort to prove its "scientific" foundation to legitimize its status as a medical profession. Hydrotherapy, lobotomy, crude psychosurgery, and electroconvulsive therapy - initially without using general anesthetics - were common treatment methods for patients with severe mental health problems such as depression, schizophrenia, and mania, and often resulted in serious side effects and health complications. The effectiveness of these treatment methods was questioned and, according to Rae-Grant (2001), contributed to the low status of psychiatry, particularly throughout this time period.

Before the deinstitutionalization of mental health care, the Canadian Mental Health Association attempted to de-stigmatize mental illness and change public perceptions of mental health. They encouraged discussion on the derogatory terminology common in contemporary legislation that referred to individuals with mental illness as idiots, imbeciles, or lunatics. They also increased awareness of the consequences of this terminology by promoting campaigns on mental health among the general population. Federal grants helped finance these campaigns, improve services, and develop professional training of service staff (Greenland, Griffin & Hoffman, 2001; Kirby, 2004a; 2004b).

Deinstitutionalization (1960s-)

Deinstitutionalization freed patients from the system of mental institutions, but initially left no support to facilitate their incorporation back into their communities. It occurred in two phases: the incorporation of mental healthcare

into general healthcare; and the subsequent necessity to expand public healthcare to manage new client/patient demography. Returning World War II veterans who filled psychiatric hospitals vastly outnumbered patients in non-psychiatric hospitals. The existence of understaffed psychiatric institutions lacking effective treatment methods as well as growing scientific research in Europe and North America showed that long-term institutionalization had detrimental effects on patients' well-being (Kirby, 2004b). In fact, the health conditions of institutionalized patients deteriorated over time and were marked by the loss of social abilities and increased dependence on care (Greenland, et al., 2001; Kirby, 2004b). The advent of anti-psychotic drugs, particularly chlorpromazine, along with funding changes that exacerbated functional pressures represented additional factors that motivated the process of deinstitutionalization of mental health care in Canada (Greenland, et al., 2001).

On the one hand, deinstitutionalization in the United States was the result of federal legislation that provided funds to individual state governments who replaced psychiatric hospitals with new community mental health systems (Wasylenki, 2001). Alternatively, in Canada, deinstitutionalization resulted in the downsizing of large psychiatric hospitals and expanding psychiatric units in general, free-standing, hospitals (Greenland, et. al. 2001; Hartford, Schrecker, Wiktorowicz, Hoch, & Sharp, 2003; Sealy& Whitehead, 2004). This is commonly referred to as the first phase of the deinstitutionalization process in Canada, beginning in the early 1960s and continuing until the 1980s. The Canadian approach to deinstitutionalization, outlined in the report of the Canadian Mental

Health Association, *More for the Mind* (1963), recommended this form of "medical integration" (Wasylenki, 2001). The recommendation was accepted largely to shift some of the burden on provincial funding for psychiatric hospitals to the federal government but also to minimize the stigma diving mental and physical illnesses (Kirby, 2004b; Wasylenki, 2001).

This structural change was not smooth, since both psychiatric and general hospitals were reluctant to accept it: psychiatric hospitals were concerned about decreased funding and some general hospitals did not want psychiatric patients. Only after a large number of clients had already been discharged from psychiatric hospitals did provincial governments acknowledge that existing general hospitals and minimal community mental health centres could not accommodate an increasingly heterogeneous population of clients with complex needs. The focus of care during this phase was based on traditional hospital-provided care with little attention paid to psychosocial and rehabilitative care (Wasylenki, 2001).

The second phase of deinstitutionalization recognized that, to increase quality of care, expansion of community mental health services was necessary (Greenland, et al, 2001; Hartford, et al, 2003; Kirby, 2004b; Wasylenki, 2001). As a result, the provincial governments began funding mental health programs specifically for individuals with severe and persistent mental health problems. According to Wasylenki (2001), by the mid 1980s, mental health services had become compartmentalized and lack coordination. The mental health "system" was described as "three solitudes": provincial psychiatric hospitals (PPHs)

operating in reduced capacities and often separated from communities; psychiatric units located in general hospitals (autonomous corporations) with little accountability but greater flexibility in serving populations of their choice; and community mental health services that were underfunded and disconnected from the rest of the treatment system (Wasylenki, 2001, p. 97). The increased focus upon effectiveness of care at the end of the 1980s, the unmet needs of severely mental ill populations resulting in movement of consumers and their family members, as well as issues of comorbidity were some of the rationales for mental health reform in individual provinces. The shortcomings of the process of deinstitutionalization led to a re-examination of the Canadian Mental Health Association's recommendations in the *More for the Mind* document and the production of the new document called *A Framework for Support* (3 editions 1980, 1993, 2004) with special emphasis on consumer participation in shaping mental health services (Pomeroy, Trainor & Pape, 2002).

The third phase of deinstitutionalization was marked by an increased emphasis upon the effectiveness of care, supported by integration and rationalization of mental health services. Evidence-based practices developed by the Health Systems and Consulting Unit of the former Clarke Institute of Psychiatry (1997) identified the services and practices necessary to a balanced mental health system and, according to Wasylenki (2001), represented an important impetus in the institution-to-community paradigm shift. The use of evidence-based practices is expected to allow for better coordination of mental health care and to facilitate reforms. The most significant change in the mental

health system in Ontario has been related to the restructuring of provincial health care that would allow "local control" through regional health care authorities (Barker, 2007). I will explain the process of restructuring the Ontario mental health system in my findings in Chapter 5 and will interpret these changes using the perspective of institutional theory. The increased focus upon effectiveness and performance-based treatment outcomes have since become hallmarks of this last phase of deinstitutionalization (Mechanic & Rochefort, 1990; Scheid, 2004).

Whatever the original intentions of this, the biggest movement in contemporary mental health policy, deinstitutionalization has been frequently criticized for releasing clients into unprepared communities, contributing to an increased number of substance abuse problems among populations with mental illness (Drake, et al., 1991; Tsemberis & Eisenberg, 2000; Tsemberis, Moran, Shinn, Asnussen, & Shern, 2003). This has also been exacerbated by disjointed or non-existent policies on "affordable" housing, income support, and mental health management which put these populations at greater risk of homelessness, poverty, and other negative consequences that would hinder their recovery (Forchuk, Turner, Joplin, Schofield, Csiernik, & Gorlick, 2007).

The community care movement on the other hand, has led to changes in psychiatry that built a stronger public health network that incorporated this movement's language and actions; as a result, primary, secondary, and tertiary prevention of mental disorders have been implemented into the psychiatric system of care (Eaton, 2001). Still, treatment for mental health problems often

fulfills a custodial function rather than a therapeutic one, particularly for clients with chronic and persistent mental health conditions who require longer, coordinated, and multiple treatment interventions (Eaton, 2001; Horwitz, 2002; Scheid, 2004). One of the responses of the health care system is case management that attempts to address the problem of low treatment effectiveness and to co-ordinate fragmented services. American scholars (Minkoff, 1997; Scheid, 2004; Schlessinger & Gray, 1999) assert that managed care in the United States has not been accepted by some clinicians who see themselves primarily as therapists and are reluctant to comply with the concept of technically based efficiency of treatment. Mental health delivery services, depending upon indetermined technologies (Hasenfeld, 1992a), are negatively affected when adapted to wider institutional changes, e.g. to the broader environment of general health care (Schlessinger & Gray, 1999).

Substance Use Problems Treatment Services in Ontario

Treating substance use problems in Canada has a history dominated by moralistic attitudes and a general lack of attention to therapeutic treatment, particularly during the first half of the 20th century (Csiernik & Rowe, 2003; Kirby, 2004b). The most significant step towards a more humane approach to treatment of alcohol and drug problems was initiated through the fellowship of Alcoholic Anonymous, starting in the United States in 1935. For almost four decades, the treatment of alcoholism in North America, including Ontario was governing by lay and self-help groups (Csiernik, 2003a)

The Kirby Commission identified five phases in the development of treatment services. The first phase ended in the late 1940s with a few private service providers who abandoned most alcohol or drug users to deal with their addictions alone, citing clients' "lack of will power" or "personality defects" (Kirby, 2004b, p. 144).

During the second phase, ending in the mid 1960s, the significance of the Alcoholics Anonymous (AA) movement promoted alcoholism as an incurable disease that could be controlled by life-long adherence to the 12-step fellowship. Federal and provincial efforts to institutionalize treatment services for the substance using population resulted in provincial mandates that initiated the development of treatment systems loosely connected to the health care system (Room, Stoduto, Demers, Ogborne, & Giesbrecht, 2006). The authors quote Mäkelä et al. (1981), who states that in this time period a number of Western countries were building treatment systems as a form of "cultural alibi" for increasingly liberal alcohol policies. On the other hand, the global policies on illicit drugs were further consolidated after the United Nations' 1961 Single Convention of Narcotic Drugs and the 1971 Convention on Psychotropic Drugs that provided the guidelines for extended drug control around the world (International Narcotics Control Board, 1961). In Canada, provincial treatment agencies that were established to construct alcohol treatment systems in their jurisdictions incorporated treatment for illicit drugs into their mandates as a response to higher demand for such services. In Ontario, the Alcoholism Research Foundation founded in 1949 became the Addiction Research

Foundation, incorporating other drug use and later problem gambling (Kirby, 2004b; Room, et al., 2006). During this time period, the focus remained upon drug enforcement and control of substance users rather than suppliers or producers of illicit drugs (Csiernik & Rowe, 2003).

The third phase began with the more general social and political changes of the 1970s as well as a growing acknowledgment of problems related to other psychoactive substances and rapid expansion of drug treatment programs. Kirby (2004b) reports that the rapid growth of addiction services in Canada between 1970 and 1976 was characterized by significant increases in expenditures for treatment services (from 14 million to 70 million) and by a larger range of services that included detoxification centres, outpatient programs, and residential and after care services. Logically, the professionalization of the addiction field partially replaced the dominant role played by recovering addicts primarily through self-help groups such as Alcoholics Anonymous (AA).

An important breakthrough in the punitive approach to drug use in Canada was the recommendations of the *Le Dain Commission* (The Royal Commission of Inquiry into the Non-Medical Use of Drugs, 1972) that provided a less morally and politically driven account of comprehensive drug policies along with the decriminalization of marijuana (Csiernik, 2003b). During this time period, substance use treatment in Ontario became part of the mandate of the Ministry of Health and was merged into the general health system (Kirby, 2004b; Room et al., 2006).

The fourth phase (1980s), marked by specialization and diversification of services, was driven by research indicating the heterogeneity of populations with substance use problems regarding their experiences and the consequences of misuse. At the same time, the "War on Drugs" in the United States was influencing changes in the Canadian drug policy. These factors will be more closely examined in my research findings in Chapter 5. Treatment interventions became informed by the development of various theoretical approaches to substance abuse treatment - cognitive, behavioral, and social theories as alternatives to the existing medical model (Kirby, 2004b).

In the fifth phase, in a similar vein to developments in mental health services, addiction treatment services experienced a number of re-structuring attempts to include them as part of the national health care system during the 1990s (Kirby, 2004b; HSRC, 2000). Addiction treatment centres were integrated into community mental health centres and social services. The attention to drug addiction was overemphasized by political agendas, and became the subject of heated debates about how effectively liberal views could address substance use among different populations.

Although the emergence of formal addiction treatment has been associated with health-oriented perspectives, unlike in the mental health field, the professionalization of the addiction field has never reached the same level as professionalization in mental health services. The increased role of neurobiological research in addiction field, however, has prompted greater attention to pharmacotherapeutic treatment of substance use problems (Flanzer,

et al., 2001; O'Connell, 2002). This development, at the same time, contributed to the ongoing dichotomy between medical and nonmedical professionals in addiction treatment: psychiatrists remained focused on higher-status areas informed by neuroscience instead of dealing with "personal troubles" that remain the areas of psychologist, but mostly social workers (Horwitz, 2002). The division between medical and non-medical professionals has since intensified because individuals with substance use problems usually seek the help of medical professionals as a result of psychological and social problems associated with drug use, the domain of non-medical professionals (Blackwell, 1993; 1998). The wider bio-psycho-social model of addiction treatment and recovery has attempted to account for multiple risk factors such as social marginalization, racial and gender inequalities, as well as poverty and problems with housing (Blackwell, 1993; 1998). In this attempt, the bio-psycho-social model partially replaced the dominant role of self-help groups such as Alcoholics Anonymous (AA). At the same time, the disease model of addiction is still widely used by non-medical professionals and people in recovery and plays an important role in community addiction services and self-help groups (Beauchesne, 1997; Csiernik & Rowe, 2003; Health Canada, 2001).

With the exception of abstinence-oriented programs, interventions emphasizing the harm reduction approach have been continually adopted over the past twenty years (CAMH background Paper on Harm Reduction, 2008; Hobden & Cunningham, 2006; Marsh & Fair, 2006). Controversy over implementing harm reduction approaches has been periodically fueled by

different ideologies of provincial and federal governments. In programs informed by the harm reduction perspective, both medical and non-medical professionals provide assistance in monitoring the physical, psychological, and social well-being of clients. Minimizing the risk of the spread of infectious diseases by providing sterile needles, syringes, and methadone maintenance have been the main interventions provided along with assistance for better living conditions including vocational, housing and welfare supports (Health Canada, 2001; CAMH, 2003).

Problem Gambling Treatment Services in Ontario

The development of services for the treatment of problem gambling in Canada and Ontario was preceded by changes in the perception of gambling as a form of entertainment and a reputable provincial government business to facilitate economic development (Derevensky & Gillespie, 2005). Two distinct historical trends were identified in the development of gambling in Canada: first, a transition from prohibition to legalization; and second, a transition of responsibility for gambling venues from the federal government to provincial authorities. The regulation of gambling has remained under federal legislation since its inception in 1892 with a general ban on gambling, with the exceptions of on-track betting and small "games of chance" at annual fairs and exhibitions (Derevensky & Gillespie, 2005). The major breakthrough in the legalization of gambling came with amendments to the Criminal Code in 1969, which allowed provincial and federal governments as well as charitable organizations to actively

introduce newer forms of gambling, including provincial lotteries and sweepstakes. The main impetus for the liberalization of gambling was the debt caused by the 1967 World's Fair and 1976 Olympics in Montreal (Canada West Foundation, 1999; Derevensky & Gillespie, 2005). Another important amendment to the Criminal Code took place in 1985, heralding a new era of gambling expansion in Canada. This new legislation permitted the operation of electronic machines, including video lottery terminals and slot machines, and provincial authorities gained significant regulatory powers in adapting gambling policies to the particularities of each jurisdiction (Canada West Foundation, 1999).

Prior to the expansion of formal treatment for problem gambling during the 1990s, assistance for people with gambling problems had been provided by mutual help groups such as Gamblers Anonymous (GA), the first of which was established in Toronto in the 1960s (Korn, 2000). The origins of GA date back to 1957 when this fellowship movement was established in the United States using similar principles to the AA movement (Hargreave & Csiernik, 2003). Following initiatives put forward by individuals who had experienced the negative consequences of their gambling behaviour, the *Canadian Foundation on Compulsive Gambling* was established in 1983. Its main purpose is to advocate for health and social services for compulsive gamblers (Korn, 2000). After the proliferation of government-owned gambling venues in Ontario, treatment for problem gambling became part of the addiction services throughout the province. More than 40 community addictions treatment centres received the resources

necessary to include the treatment of problem gambling in their mandates. This top-down approach to the development of problem gambling treatment services has been in stark contrast with the development of treatment services for other addiction problems, particularly for people with addictions to illicit drugs. This will be discussed further with a more detailed review and interpretation of changes in the problem gambling sector in my research findings in Chapter 5.

Problem gambling initiatives in Ontario have been guided by the Ontario Problem Gambling Strategy (1996) outlining allocation of provincial finances for services such as prevention, treatment, and research (Sadinsky, 2005); however, this document provides very little direction for the development and coordination of services for problem gambling. The funding for prevention, treatment, research, and training of problem gambling counselors remains more generous than for other addictive behaviors, since the money is provided from two percent of the gross revenue from slot machines at charity casinos and racetracks. The MoHLTC has prioritized the development of a formula for the allocation of this financial support as follows: 60 percent for treatment, 22 percent for prevention and awareness, and 18 percent for research. Among the stakeholders with specific tasks is CAMH's Problem Gambling Project which provides training to the problem gambling treatment network and allied professionals.

The report by Sadinsky (2005) to the Ontario MoHLTC and Ministry of Economic Development and Trade underscores that the majority of data on gambling in Ontario indicate the existence of populations experiencing significant social, economic, and psychological problems due to their gambling behavior; 80

percent of the adult population take part in some form of legalized gambling with 0.9 percent of adults with severe gambling problems accounting for approximately 64,000 people, and 3.8 percent with moderate gambling problems accounting for 288,000 people. However, only 3,800 people sought help or treatment for their gambling problems in the fiscal year 2003-04 (Sadinsky, 2005).

To summarize, addiction treatment services in Ontario have been subjected to changes that reflect the sentiments towards substance use and problem gambling in the broader political, economic, and social environment. In general, substance use services have lacked national and provincial leadership and consistent and sufficient financial support.

The differences in accessibility of specialized addiction treatment in rural areas remain a significant challenge in treatment delivery. At the clinical level, some services still lack the skills needed to enhance the quality of their treatment and adopt newly developed treatment approaches. The same lack of skills applies to the treatment of problem gambling, formally organized within substance use treatment sector. Although more generously funded, it also faces the challenges associated with the professionalization of its clinical workforce and its recognition as a treatment specialty.

Another problematic factor in the addiction sector is that challenges and pressing issues have been experienced in addressing populations with complex needs, such as co-occurring mental health and substance use problems. An example would be the reluctance of abstinence-only oriented staff to use

psychiatric medication for people with mental health problems (Roberts & Ogborne, 1999). In the past, this issue was identified as one of the contributing factors in accessing addiction services by people with co-occurring substance use and mental health problems (Health Canada, 2001; Minkoff, 2001).

2.3 Organization of Treatment for Concurrent Disorders

Individuals with co-occurring psychiatric and addictive disorders are also associated with poorer treatment outcomes and higher treatment costs. Moreover, the literature on the co-occurrence of mental disorders and addictive behaviors indicates that people who experience problems with more than one diagnosis tend to be viewed by service providers as a difficult subpopulation to serve (Drake & Mueser, 2000).

Historically, services for individuals with concurrent disorders have been delivered separately by the mental health care and addiction treatment systems, providing either "parallel" or "sequential" treatment (CAMH, 2003; Health Canada, 2001; Minkoff, 1998). Drake and Mueser (2000) state "in the sequential treatment approach, patients were directed to obtain definitive treatment in one system before entering treatment in the other system" (p.107). Sequential treatment remains a necessary approach in cases when acute conditions of one disorder have to be addressed first to avoid seriously endangering an individual's life (Health Canada, 2001). However, sequential treatment is ineffective in cases when stabilizing one disorder depended on the

simultaneous stabilization of the other (Hendrickson, 2006). Parallel treatment refers to such simultaneous treatment of both psychiatric and addictive disorders but is conducted by two separate agencies or departments. Its ineffectiveness has been proven due to the often irreconcilable logistical difficulties and philosophical differences for clients participating in two separate programs (Health Canada, 2001; Hendrickson, 2006). According to Minkoff (1997) "the estrangement of the addiction system from mainstream mental health has its origin in the development of the 12-Step recovery movement - over 50 years ago – as an alternative to the usual medical treatment of addiction, which was essentially non-existent" (p. 233). He further states that separation the system in this manner was taken for granted to the extent that practitioners now accept it as normal.

In addition to reports on low efficiency, both approaches have been widely criticized for poor treatment outcomes and overall ineffectiveness for clients who often "fall through the cracks" of the system (Health Canada, 2001; Kimberley & Osmond, 2003; Minkoff, 1997; 1998). Another problematic issue arising from disjointed systems of care is that no regular screenings or assessments are conducted for other disorders, falling outside their own treatment mandates, which their clients may possess. Obviously neither system is sufficiently equipped to deal with clients' multiple needs (Hendrickson, 2006). Mueser, et al. (2003) attribute this to the inability of these bureaucratically separate services to adequately address the complexity of concurrent disorders. The authors explain that poor integration of services is a result of divergent

treatment philosophies that vary the process of legitimization among these services. As a result of differing societal views on mental health and addiction problems - the latter being considered a self-inflicted condition - mental health patients now receive greater support from treatment resources. Substance users are often perceived as undeserving of care and are expected to feel the consequences of their irresponsible behavior. Contradictory messages about recovery from mental health and addiction service providers also tend to reduce the possibility of clinical improvement of concurrent conditions. Barriers in funding prevent clients from accessing comprehensive treatment services and pose difficulties in navigating both systems. Moreover, poor treatment outcomes and resources in the non-integrated treatment of concurrent disorders are at further risk in task-oriented environments where it is difficult to secure financial support and legitimacy in the community.

The Frameworks for Integration of Treatment for Concurrent Disorders

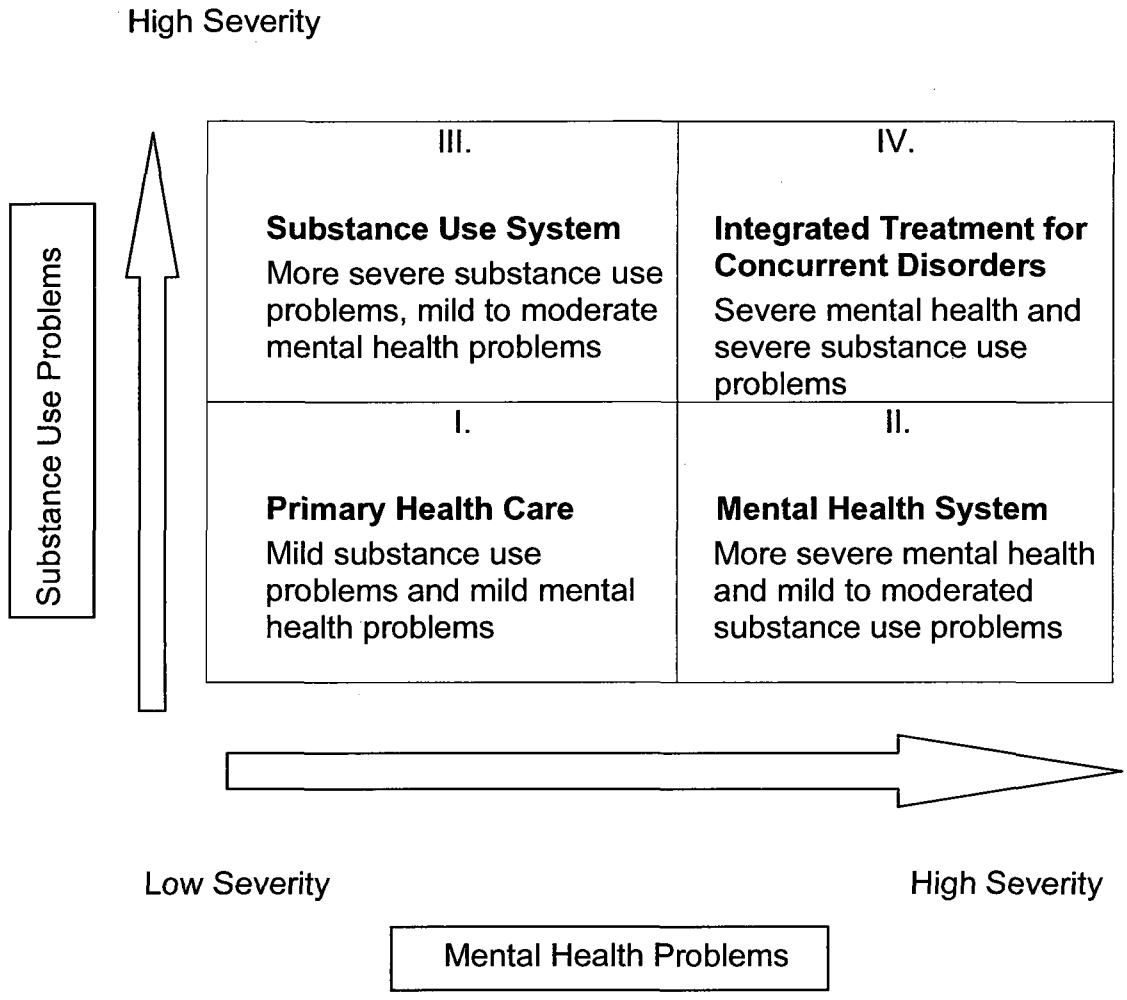
The model of integrated treatment has been generally accepted as the most effective treatment for individuals with co-occurring disorders (Drake et al., 2001; Health Canada, 2001; Hendrickson, 2006; RachBeisel, Scott, & Dixon, 1999; Substance Abuse and Mental Health Systems Administration [SAMHSA], 2002). On the program level, the suggested model of care for chronic mental disorders and severe addictions is the integration of treatment interventions to simultaneously address clients' multiple needs using the knowledge and skills of clinicians with various professional backgrounds who are trained in both fields

(Health Canada, 2001). Clinical studies focused on the integration of treatment of chronic mental health disorders and severe substance use have helped to build evidence about the positive outcomes of this treatment model (Drake, et al., 2001; Drake & Mueser, 2000; Drake & Wallach, 2000; Health Canada, 2001; Hendrickson, 2006; Mueser, et al., 2003).

The Four Quadrant Model

The framework for addressing the integration of treatment from the systemic perspective, *The Four-Quadrant Model* (Table 2.1), has been developed as a heuristic tool for planning appropriate treatment interventions. The model specifies the level of service coordination based on the severity of both mental health and addictions problems: the greater the severity, the more intense the level of integration or dependability of services that needed (CAMH, 2003; Concurrent Disorders Ontario Network, 2005; Puddicombe, Rush, Bois, 2004; Skinner, O'Grady, Bartha, & Parker, 2004).

Table 2.1: The Four-Quadrant Model



In Quadrant I, primary health care can provide treatment for those with low severity substance use and mental health problems. Services in Quadrant II and III are either specialized substance use or specialized mental health services. These must collaborate or utilize referrals in order to address the co-occurring disorder for which they lack specialization. If the co-operation and co-ordination of services is not effective, the burden to connect the services usually falls on clients. Quadrant IV requires bringing together specialists from both service and addressing chronic conditions of mental health and substance use disorders in one specialized and integrated service.

This model belongs to the category of approaches that attempt to plan services based on the individual's ability to function in the community. It has, however, been criticized for its imprecise descriptions of severity and for gaps between "quadrants", specific treatment services, and treatment settings (Sacks, Chandler, & Gonzales, 2008).

Hendrickson (2006) reports that the development of such a model should be preceded by asking the questions "*Which clients can be treated together?*" and "*What level of services do they need?*" (p. 35, italics in text)

The Dual Disorders Typology

The dual disorders typology elaborated by Zimberg (1999) is comprised of 3 subtypes: Type I - Primary psychiatric disorder, Type II - Primary substance

abuse disorder, and Type III - Dual Primary disorders. According to Zimberg(1999), dual diagnosis typology has been developed in response to the "lack of [a] reliable and valid approach to diagnosis considered as a major roadblock to effective integration of psychiatric and substance abuse treatment" (p. 47). Moreover, uncertainties relating to the diagnosis of co-occurring mental health and substance use disorders lead to the development and use of confusing terminology often regarded as clinically meaningless (Zimberg, 1999).

The dual diagnosis typology designates the primary disorder based on the characteristics of its onset rather than a coordinated analysis of both disorders. For example, Type I is regarded as a primary psychiatric disorder with associated substance use problems. Based upon this model, patients use psychoactive drugs to ease or alleviate their psychiatric symptoms and therefore self-medicate (Khantzian, 1997; 2003). Patients who develop substance-induced psychiatric conditions are diagnosed as having a primary substance use disorder under Type II. In this case, a substance use disorder clearly exists before the onset of the psychiatric disorder and the course of substance use affects episodes of psychiatric disorder. The typical example of Type II is a client who meets the criteria for a depressive disorder while being dependent to alcohol or other drugs. Type III encompasses both psychiatric and substance use disorders. Patients typically have long-term psychiatric and substance use disorders occurring simultaneously or separately.

This classification system is important for assisting in the assessment and planning of treatment services, although according to Zimberg (1999) the access

to fully integrated programs is limited by a lack of long-term intensive case management programs.

The Dartmouth School

The model most elaborated upon and clinically tested is *the integrated treatment program model* for populations with chronic mental health disorders and severe substance use (Drake & Mueser, 2000; Drake, et al., 2001; Drake, & Wallach, 2000; SAMHSA, 2002). This model emphasizes the importance of addressing both mental health and substance use problems simultaneously by members of a single coordinating team (Drake & Mueser, 2000; Health Canada, 2001; Kimberley & Osmond, 2003). This model emphasizes inclusive treatment interventions by addressing a wide range of clients' needs. Although clinicians have approached the phenomena of integration in various ways, according to the model developed by Drake et al. (2001), the vital components of integrated treatment are staged interventions, assertive outreach, motivational interventions, counselling, social support interventions, long-term program perspective, and cultural sensitivity. Guiding the implementation of integrated treatment are principles of flexible and specialized clinicians and comprehensive services that include addressing the full range of clients' needs such as stable housing, vocational rehabilitation, and social networking (Mercer, Mueser, & Drake, 1998; Minkoff, 2001; Torrey, Cohen, Fox, Lynde, & Gorman, 2002).

The integration of treatment interventions for people with mental health and drug use problems is generally regarded as assisting in the achievement of optimal treatment outcomes (Drake, et al., 2001; Drake & Mueser, 2000;

RachBeisel, Scott, & Dickson, 1999). According to Health Canada (2001), there are two levels of integration: the program level when "mental health treatment and substance abuse treatments are brought together by the same clinicians/support workers, or teams of clinicians/support workers in the same program"; and the system level integration, characterized as "the development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of service to individuals at the local levels" (p.15). Degrees and means of integration usually differ depending on the needs of clients and resources of particular systems.

Clients who can potentially benefit from an integrated approach are those who experience "'ping-pong' therapy in which the individual becomes a 'system misfit' bouncing back and forth between the two service systems" (Minkoff, 1997, p.235). The low effectiveness of this therapy results in patients being further stigmatized (Drake, et al., 2001; Drake & Mueser, 2000; Health Canada, 2001). Integration of treatment for concurrent disorders is considered highly preferable not only from the clients' perspective but also for managed care organizations. Managed care organizations in the US have shown a preference to contracts with fewer and more comprehensive providers "under the one roof" or so-called "one-stop shopping", than supporting numerous small disjointed service providers (Minkoff, 1997, p. 236).

In Canada, we have witnessed a blurring of the lines between mental health and addictions services (Health Canada, 2001); however, there is lack of research examining why integration has become so significant. Is it a result of

efforts to seek more comprehensive treatment interventions, or a response to the increasing power of certain professional groups, or other political, bureaucratic, or financial reasons?

2.4 Concluding Remarks

This literature review demonstrates the role that different concepts of mental health and addiction problems have in the development of treatment measures. I have illustrated how perceptions of mental health problems, drug dependency, addiction, problem gambling, and related terms have shaped the organizational response to these phenomena in Canadian society. The identification of mental health problems incorporates judgments on normal versus abnormal behaviour that are also influenced by the political, cultural, and social position of the "observer" as well as the various social positions of individuals with these problems (Horwitz, 2002). Historically classifications of mental health problems were applied only to a small number of severely disturbed conditions, but this number has exploded over the past few decades and has led to an increasing number of medical specializations (Eaton, 2001; Gergen, 1999; Horwitz, 2002; Kandall, 1996).

To provide context for the later analysis of my findings, I have reviewed the literature outside of a social work discipline. Some of the models, such as the medical model, have had direct bearing on the way treatment for mental health, substance use, and problem gambling has become a normative practice.

The fact that concurrent disorders encompass mental health and addiction problems that have both been widely stigmatized has been a unifying concept for better understanding of concurrent disorders.

As public opinion towards both conditions shifted over time due to socially constructed differences identified in the aetiology of mental health and addiction, these changes have been reflected in the different status of both mental health and addiction problems. Addiction is still widely perceived as a self-induced condition while mental health problems are considered conditions which a person is not directly responsible for (Polak, 2000). Problem gambling also has a distinct status. Even though it has been medicalized by its classification as mental health disorder, it remains the least institutionalized concept of the three. Placed within addiction treatment services, its status reflects the fact that it is associated with a different social class than illicit drugs and its recreational form is a revenue-creating activity (Hargreave & Csiernik, 2003).

This review of literature on different models for the treatment of concurrent disorders also shows that, apart from co-occurring mental health and addiction problems present in different treatment settings, there have been various frameworks for classifying concurrent disorders and outlining models for their treatment. These frameworks attempt to provide better understanding of the disorders by focusing on the aetiology of concurrent disorders (Zimberg, 1999) and attempt to achieve a better clinical integration of primary and specialized services based on chronic nature and severity of both conditions (SAMHSA, 2002). Other frameworks focus on different components of integrated treatment

in community for individuals with chronic mental health and substance use problems (Drake et al. 2001; Drake & Mueser, 2000). In the next chapter, I will provide an overview of the conceptual framework used in this study to identify how some of these models became institutionalized.

Chapter 3:

Theoretical Framework

Introduction

To contextualize the historical development of concurrent disorders in order to comprehend the organization of treatment, I will draw on neo-institutional theory (DiMaggio & Powell, 1983; Hasenfeld, 1971; 1972; 1990; 1992a; 1992b, 2000a; 2000b; Meyer & Rowan, 1977; Scott, 1986; 2001; 2008; Scott & Meyer, 1994; Zucker, 1987) as a conceptual framework that will guide the interpretation of my research findings.

3.1 Institutional Theory Development

Early concepts of the institutional analysis of organizations suggested an adaptive organic system. This understanding of an organization as an open system affected by the social attributes of organizational environments stands in stark contrast to the concept of a simply a mechanistic instrument driven by rational decisions to achieve specified goals (Perrow, 1986; Selznick, 1957; 1996; Scott, 2008). The adaptive organizational process that forms in reaction to external environments is referred as institutionalization (Scott, 2008). Jepperson (1991) in his adaptation of Zucker's (1983) conceptualization of institution asserts that institutions "represent social order or a pattern that has attained a certain

state or property; *institutionalization* denotes the process of such attainment" (italics in text) (p. 145).

Early institutional theorists, particularly Selznick (1948; 1957; 1996), stated that the development of organizational structures through the process of institutionalization is affected by their understanding as cultural objects; "'to institutionalize' is to *infuse with value* beyond the technical requirements of the task at hand" (Selznick, 1957, p. 17). Consequently, the process of institutionalization results in the acquisition of a distinct identity or a "character structure" for a particular organization (Scott, 2008, p. 22), and these organizations' complex functions preserve their unique values. Accordingly, institutionalization becomes the "process of organic growth, wherein the organization adapts to the strivings of internal groups and the values of the external society" (Perrow, 1986, p. 167).

Perrow (1986) summarizes the contribution of the "old" institutional school in three main areas: first, with an idea of the variability of organizations that simultaneously share some basic characteristics, such as their dependency or relative autonomy; second, by recognising the organizations' potential to command their own interests in pursuing independent goals; and third, with the institutional school's emphasis on the importance of the environment in which organizations are embedded. Issues of power and conflicts of interests, as well as the belief that certain values and interests within organizations can only be preserved when protected by those who hold authority, also resonate in the evolution from "old" institutionalism (Stinchcombe, 1968).

DiMaggio and Powell (1991) have compared the aspects of the two institutional schools, "old" and "new", as follows:

> [N]eoinstitutionalism traces its roots to the "old institutionalism" of Philip Selznick and his associates... [b]oth the old and new approaches share a scepticism toward rational-actor models of organization, and each views institutionalization as a state-dependent process that makes organizations less instrumentally rational by limiting the options they can pursue. Both emphasize the relationship between organizations and their environments, and both promise to reveal aspects of reality that are inconsistent with organizations' formal accounts. Each approach stresses the role of culture in shaping organizational reality. (p. 12)

Neo-Institutional Theory

Initial attempts to formulate neo-institutional concepts are traced to Silverman (1971) who propounds the "action" theory of organizations, challenging earlier concepts of contingency theory and structural functional views of stability and organizational systems (Scott, 2008). Silverman (1971) challenged the notion of human behaviour as a reflection of the characteristics of a social system containing impersonal processes which constrain the actors. He proposed the social construction of reality as a theoretical background of organization theory in that meanings do not operate only in the minds of individuals but are also present as "social facts" in social institutions and their environments (Scott, 2008, p. 42). Theorizing on Berger and Luckman's (1980) concept of institutionalization, Lloyd (1993) states that institutionalization occurs as a reciprocal "typification" of "habitualized" actions; however, the actions are not institutionalized instantly and instead become part of the process of interpretation and co-construction of reality. Berger and Luckman's (1980)

concepts have been further elaborated upon by DiMaggio & Powell (1983), Hasenfeld (1985, 1992a, 1992b, 2000a, 2000b), Meyer & Rowan (1977), Scott (1986, 2001), Scott & Meyer (1994), Tolbert & Zucker (1996), and Zucker (1987/1991).

Meyer and Rowan (1977) and Zucker (1987) perceive institutionalization as a process by which social phenomena are taken for granted and begin to function as rules. Organizations are viewed as the complex systems in which those rules can be cultural, normative, or rationalized institutional beliefs. The rationalization of rules is supported by various professional groups, governments, communities, media, and other entities who aim for the growth and continued sustainability of a large number of organizations. The new organizations which emerge from previous ones are thus forced to incorporate frameworks, concepts, and practices that were developed and institutionalized by the previous environment. In doing so, newly evolved organizations have the opportunity to increase their legitimacy and thus improve their chances of survival. This can occur even if the acquired practices and procedures are not effective and are identified as rationalized myths. Meyer and Rowan (1977) describe the adaptation of rationalized myths or "shared-belief systems" as follows:

> Institutionalized products, services, techniques, policies, and programs function as powerful myths, and many organizations adopt them ceremonially. But conformity to institutionalized rules often conflict sharply with efficiency criteria and, conversely, to coordinate and control activity in order to promote efficiency undermines an organization's ceremonial conformity and sacrifices its support and legitimacy. To maintain ceremonial conformity, organizations that reflect institutional rules tend to buffer their formal structures from the uncertainties of technical activities by becoming loosely coupled, building gaps between their formal structures and actual work activities. (p. 340)

A typical myth-like form can be created from effective practice or specialization emerging in organizations that share similar relational contexts. These myths gain legitimacy based on their alleged effectiveness or are based on legal mandates. The leadership of local organizations can force close relational networks, such as subcontractors, to adapt to structures of their organizations and, at the same time, powerful organizations can adapt their goals and procedures to society by creating standards and expectations for the services they are providing (Meyer & Rowan, 1977/1991).

The existence of institutionalized rules as rationalized myths in the form of professional ideologies is periodically affirmed through symbolic actions such as accreditation, certification, utilization of best practices, and the like (Meyer & Rowan, 1977/1991). Organizational units, despite having the best intentions to adapt, may still fail to do so because of various pressures imposed by external stakeholders or other common limitations including: insufficient information processing and perceptual mechanisms; lack of resources and insufficient technology; inadequate professional training of personnel; and the personal values and beliefs of those personnel members (D'Aunno & Price, 1985,

Hasenfeld, 2000a; 2000b; Scott, 2001). Organizations that want to survive are forced to maintain institutional rules because they serve as a source of legitimacy and as pathways to resources (Meyer & Rowan, 1977/1991; Mohr, 1992).

The new institutionalism recognizes existing conflicts of interests and emphasizes that organizations respond to such conflicts by developing sophisticated and elaborate administrative structures. At the same time, it identifies different constraints on institutional environments, such as the relationship between stability and legitimacy (Zucker, 1987). The new institutionalism also views the formal structure itself as irrational, attributing the intra-organizational changes to various inter-organizational influences such as conformity and the persuasiveness of cultural accounts, rather than to the functions they are meant to perform (DiMaggio & Powell, 1991).

3.2 Mechanisms of Institutional Isomorphic Change

In order to survive, organizations tend to become isomorphic in relation to their environments. Organizational isomorphism is an attempt to imitate the technical and exchange interdependencies of environments within the structure of an organization.

Since the concept of institutionalization does not rely on one distinctive process, institutional theorists seek out other elements that could potentially explain the ways organizational structures change or are re-shaped (Scott, 2008). In this regard, isomorphism within the institutionalized environment has a

profound impact on organizations. The concept of institutional isomorphism proposes that institutional pressures to conform produce three mechanisms: coercive, mimetic, and normative (DiMaggio & Powell, 1983/1991). Quoting Hawley (1968), DiMaggio and Powell (1983) describe isomorphism as the concept that best captures the process of homogenization in the organizational field:

> Isomorphism is a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions. At the population level, such an approach suggests that organizational characteristics are modified in the direction of increasing compatibility with environmental characteristics; the number of organizations in a population is a function of environmental carrying capacity; and the diversity of organizational forms is isomorphic to environmental diversity. (p. 149)

Coercive Isomorphism

Apart from acknowledging the presence of competitive isomorphism in the population ecology concept of Hannan and Freeman (1977), organizations have to compete for political power and institutional legitimacy, with the exceptions of market competition and niche changes. Coercive isomorphism is believed to result from political influence, in particular the pressures on organizations by the environment, other organizations, and cultural expectations. Such change can be endorsed by various kinds of persuasion ranging from direct governmental policies to voluntary coalitions based on mutual benefits (DiMaggio & Powell, 1983/ 1991). In some cases, organizational adaptation is in direct response to specific mandates by the government which increases homogeneity. The

established fields and domains of organizations become entrenched within institutionalized environments (Meyer & Rowan, 1977/1991). The imposition of legitimated rules and structures is present outside of governmental pressures in the forms of best practices, performance evaluations, and other policies similar to affirmative action, which allow organizations to utilize more external support. Flood and Fennel (1995) use regulatory programs in the health care sector as an example of coercive isomorphism, detailing the prospective payment system for American Medicare hospital reimbursements in 1983. Every hospital, in order to be reimbursed for the care of Medicare patients, had to adopt the system. In Canada, an example of government-imposed changes in mental health and addiction systems were mergers, closures, and creations of networks of service providers during the 1990s (HSRC, 2000).

Mimetic Isomorphism

Organizations experiencing uncertainty over external conditions can simply model other successful establishments (DiMaggio & Powell, 1983/1991). Mimetic behaviour of organizations is considered an appealing means of organizational change that can decrease the level of uncertainty experienced by an organization within its institutional environment; however, it does not necessarily increase the efficiency of organizational practice. In the case of poorly defined technologies, ambiguous goals, and overall unpredictability of environments threatening organizational existence, modeling is understood as a logical response to uncertainty. It can either be implicit and unintentional or very

explicit and deliberate, due to the pressures of organizational networks within various associations. Organizations will align themselves with similar institutions they perceive to be successful. The unintentional isomorphic behaviour of organizations is present in the forms of turnovers and transfers of skilled staff. Organizations that serve as models and are copied by other organizations do not have to be aware of it. The relative omnipresence of certain kinds of organizations and structural arrangements also do not necessarily indicate an efficient model, but rather points out the universality of mimetic processes (DiMaggio & Powell, 1983/1991). In case of human service organizations, Hasenfeld (2000a) argues that because they engage in moral work, the level of institutional isomorphism can be affected by diverse views regarding interactions with clients or other organizational forms.

Mimetic behaviour can also be observed at the policy level. Lindquist (2006) and Dombrink (1996) note that external pressures for change in policy networks can originate in another cognate policy system that develops a model to be mimicked by other networks. A good example is the public health movement regarding the consumption of tobacco, which has successfully changed public behaviour through education and various restrictive measures including limited commercial availability. Lindquist (2006) points out the positive correlation between external change in one sector and the likelihood that other policy networks will be influenced in another. Policy networks that have been previously separated can intersect or converge and thus become isomorphic.

Normative Isomorphism

The normative source of isomorphic change in organizations stems from professionalization. Quoting Larson (1977) and Collins (1979), DiMaggio and Powell (1983) define professionalization "as the collective struggle of members of an occupation to define the conditions and methods of their work, to control 'the production of producers', and to establish a cognitive base and legitimation for their occupational autonomy" (p. 152). The important organizations for the development of normative organizational characteristics are universities and training centres; their legitimacy is based upon knowledge, which supports the education system and the production of professionals.

Powerful interest groups and the pressures on organizations to comply with expectations and values reflect mutable influence within key health care groups. Flood and Fenell (1995) report that physicians are considered the primary professional group within hospitals; they have been influential in the planning and growth of hospitals and also determine the selection of treatment approaches. DiMaggio and Powell (1983/1991) report that professionalization is among the field level predictors of greater isomorphic change. Although these authors suggest several hypotheses relating to the extent of isomorphism with regard to attributes such as centralization, goals, technologies, professionalization, and source dependence, the possibilities of other nonlinear effects were not fully explored. At the same time, the focus on institutional isomorphism has clarified the sources of certain myths and ceremonies which are present in organizational functioning (Meyer, Rowan, 1977/1991).

3.3 The Concepts of Organizational Legitimacy

Neo-institutionalists understand that the legitimacy of organizations is an important element in organizational survival (Powell & DiMaggio, 1983/1991; Meyer & Rowan, 1977/1991; Zucker, 1987). The greater the incorporation of socially legitimized elements in formal organizational structures allows these organizations to acquire greater legitimacy and, in turn, better access to resources to ensure their survival. The legitimacy of organizational practices is based on the belief that the actions of organizations are desirable and appropriate within socially constructed systems of norms, values, and definitions (Scott, 2001). According to Berger and Luckman (1980), "legitimation 'explains' the institutional order by ascribing cognitive validity to its objectivated meanings. Legitimation justifies the institutional order by giving a normative dignity to its practical imperatives...it has [a] cognitive as well as a normative element" (p. 86).

Johnson (2004) summarizes the impact that the neo-institutionalist perspective has on organizations pursuing legitimacy as they create and maintain structures, routines, and practices that are isomorphic within their socioeconomic, cultural, and political environments. The socioeconomic and political pressures from these can also promote homogeneity within organizational structures. While institutional theory using the open-system approach has elaborated external legitimacy, internal "legitimation" processes have been related to evaluation and exercise of authority along with organizational stability (Johnson, 2004). Zelditch (2004) therefore observes an

interrelationship between both internal and external legitimacy due to this contribution to organizational stability. External legitimacy is so important that organizations are ready to seek it even when the cost exceeds the benefits for some time. Handel (2003) illustrates how voluntary organizations might hire paid staff to replace volunteers and gain public funds since such an organization often appears more professional.

Common forms of legitimacy among institutions include certification or accreditation. The importance of individual contributing perspectives for organizational legitimacy is still unclear; legitimacy is usually influenced by those who have social power and influence in a particular environment.

Evaluation of Organizational Effectiveness

Organizations that embody external legitimacy tend to employ ceremonial assessment in order to evaluate their structural components and preserve that legitimacy. Reliable external institutions bring more stability and institutional isomorphism and secure greater success and survival for other organizations. External assessment criteria can also secure success in the form of prestigious prizes which are ceremonially awarded through the qualitative endorsement of distinguished professionals. Generally, the stability of internal and external organizational relationships is, according to Meyer and Rowan (1977/1991), dependent on the elaborate institutional environments in which they exist. Market conditions and outcomes, including technology and technological procedures, are controlled by the institutionalization of mutual agreements and

rules. Organizations in highly institutionalized environments, once they gain legitimacy, function as part of the collectively granted monopolies belonging to schools and hospitals.

Meyer and Rowan (1977/1991) admit that organizations relying only on isomorphism with institutional rules can face two kinds of problems: first, the demands for efficiency in their performance; and second, the problems that arise as the result of widely divergent environments and ceremonial rules. Activities that can enhance institutional rules and maintain rationalized myths are not necessarily effective. Moreover, evaluating effectiveness may be costly and impose a greater burden on organizational expenditures and performance. The consequences of inconsistencies detected between organizational structures and their practices can include greater resistance to ceremonial requirements and conforming to institutionalized structures by limiting external relations. Ideally these situations would encourage a push for reform.

Organizations become uncoupled or "loosely coupled" in an attempt to survive the risk of losing legitimacy due to issues of tight control and co-ordination (Meyer & Rowan, 1977/1991). This decoupling process results in ambiguous organizational goals, further ceremonial tendencies, and potential evasion when measuring organizational performance. Consequently, organizations substitute the objective measurement of organizational performance with merely good faith, leading to avoidance of, discretion about, and overlooking pertinent issues. Isomorphism, institutionalization, and professionalization, along with the delegation of responsibilities are the

mechanisms that minimize uncertainty and promote a more formal structure of organization (Meyer & Rowan, 1977/1991).

Tolbert and Zucker's (1996) summary of the concepts of organizational effectiveness developed by Meyer & Rowan (1977) shows three important implications for institutional theory. First, the adoption of formal structures does not have to be based upon rationalized concepts of organizational functioning. Second, the social evaluation of organizations can be predicated upon observation of formal structures that do not necessarily show actual outcomes. Lastly, the connection between formal structures and the behaviour of members of organizations can be irrelevant. Despite these seemingly contrary postulates, the existence of formal organizational structures is perceived as a signal of organizations' commitment to rational and efficient standards (Tolbert & Zucker, 1996).

3.4 The Three Pillars of Institutions

Scott (2008) reports that "[i]nstitutions are comprised of regulative, normative, and cultural-cognitive elements, that, together with associated activities and resources, provide stability and meaning for social life" (p. 48). Due to the processes set in motion by these three pillars, institutions become social structures built upon symbolic elements, social activities, and material resources. These elements are relatively resistant to change as they are maintained and reproduced through several generations (Jepperson, 1991; Zucker, 1977 quoted

in Scott, 2008). Although each element helps to form an interdependent and mutually reinforcing system, this model conflates three divergent concepts that must first be differentiated before one can understand their interdependent nature.

The Regulative Pillar

The regulative pillar places an emphasis upon explicit regulatory processes, such as "rule-setting, monitoring, and sanctioning activities" (Scott, 2001, p. 52). Regulatory processes have the ability to establish rules and the capacity to control them, and include the manipulation of sanctions to influence the future behaviour of organizations where necessary. Regulative elements are logically instrumental and the legitimacy of regulative powers comes from a legal recognition and sanctions, written rules or informal, unwritten codes of conduct (Scott, 2001; 2008). Coercive mechanisms are then used for the implementation and maintenance of rules and laws. Naturally, any kind of enforcement undertaken upon other social actors has been criticized over issues of neutrality and fairness. By operating more autonomously and developing its own interests, the state can utilize roles such as "rule maker, referee, and enforcer" to emphasize the explicit processes outlined by Scott (2001). He further points out that laws' coercive functions should not be conflated with their normative and cognitive dimensions because of their controversial and ambiguous nature (Scott, 2001).

The Normative Pillar

The normative pillar is based upon rules that bring prescriptive, evaluative, and obligatory dimensions into social life. Values and norms included in this system can be applied to all members of society or only to selected actors or positions. Normative systems impose constraints on human behaviour through the concept of roles. Scott (2001; 2008) states that normative roles encompass the concept of correct or appropriate goals and activities for particular individuals or social positions. They become prescriptive or normative expectations of behaviour for specified actors. In addition, when legitimate authority is involved, the normative pillar is mutually reinforced by the regulatory pillar. The normative concept for institutions has caught the attention of many sociologists and organizational theorists. They emphasize the stabilizing effect of social values, beliefs, and norms that are simultaneously internalized by individuals and imposed on others. Scott (2001) reports that findings from various studies of the institutionalization process in organizations indicate that organizations can adapt selected practices only at the beginning of institutionalization process. If practices are adopted later, it is more often required of both normative and cultural-cognitive pressures.

The Cultural-Cognitive Pillar

The third pillar emphasizes the importance of cultural-cognitive elements in institutions. Scott (2001; 2008) reports that the cultural-cognitive dimension of institutions is based upon the social constructivist view of human existence,

where internal interpretative processes are shaped by external cultural frameworks. In this case, unlike normative and regulatory methods, the importance of the mimetic mechanism to implement a common framework for developed meanings is emphasized. Compliance is based on what is taken for granted through a shared understanding of social elements of institutionalization; legitimacy is based on the recognition of the organizational practice that is simultaneously supported by and existing within a specific culture (Scott, 2008). For Scott, the "cognitive-cultural" pillar recognizes internal cognitive processes shaped by the external environment and particularly cultural frameworks.

3.5 Diffusion and "Translation" of Organizational Change

Scott (2008) asserts that institutions that encourage the adoption of institutional elements also diffuse them through multiple channels or mechanisms. First, the outward diffusion of institutional forms indicates that an institutional structure has strengthened or has significantly grown. Second, diffused organizational elements that are adopted by organizations are affected by different adoptive characteristics within organizations and the changing strength of institutionalization processes. Lastly, adopted practices are also spread as part of *convergent* change (Scott, 2008, p. 133 italics in text). However, as the author points out, disruptive and divergent organizational change has increasingly interested neo-institutional theorists (Scott, 2008).

With this interest in mind, the concept of institutional entrepreneurship has reintroduced agency into institutional analyses of organizations to offer deeper

understanding of the micro-foundations of institutionalized processes (Lawrence & Phillips, 2004). Institutional entrepreneurship has been defined as "activities of actors who have an interest in particular institutional arrangements and who leverage resources to create new institutions or transform existing ones" (Maguire, Hardy, & Lawrence, 2004, p. 657). The agency in this concept has a paradoxical nature since the rigor and conformity of institutions emphasized by "old" institutionalism have been seen to stifle individual action, a "paradox of embedded agency" (DiMaggio and Powell, 1991). By questioning the ability of individuals to promote change, this concept restores the debate on "structure-agency" that examines the abilities of dominant social actors to create change within their institutional environment (Garud, Hardy, & Maguire, 2007). Privileging structure over agency previously led to more deterministic and static models of organizational change, while theories on agency emphasize the contractive and multilayered processes in delivering organizational change.

To specify the conditions and mechanisms underpinning the process of institutionalization, Strang and Meyer (1993) theorized the model of diffusion as a socially mediated spread of practices. Theories of diffusion, often described as a spatial process, usually emphasize a rational basis for the adoption of certain practices as a result of their alleged effectiveness. Instead, Strang and Meyer (1993) suggest that it spreads through social relations, cultural linkages, and thought processes that incorporate sense-making and co-construction into the understanding of diffusion practices.

The recent shift from the concept of diffusion as a more mechanistic process to one of "translation" has promoted an exploration of the dynamics of the institutionalization of different practices as a transfer of ideas in a non-linear and constantly changing way (Czarniawska & Joerges, 1996; Czarniawska & Sevon, 1996). The translation model, according to Czarniawska & Joerges (1996) quoting Latour (1993) goes beyond its simple linguistic meaning to refer to a "displacement, drift, invention, mediation, [or] creation of a new link that did not exist before and modifies in part the two agents" (p. 24). This process includes both an active contribution of those who participate in translation and an active approach to what is being translated.

In order to conceptualize organizational change as a model for the transmission of ideas, Czarniawska and Joerges (1996) elaborate on the concept of "fashion" and the ingrained paradox of its function in the process of institutionalization. The authors recognized that although fashion and institutionalization can be considered opposites, they are both interconnected and both contribute to organizational change. Fashion as a way of creation and imitation of new ideas as they are translated can serve as a way of keeping pace with novelties in a particular field. While fashion can bring new and desired change, organizational space should still be protected from passing "fads" (Abrahamson, 1991; 1996; Czarniawska & Joerges, 1996). Organizations that attempt to either stay abreast of the competition or simply keep up with novelties in the field can do so through different channels. On an individual level this can be accomplished through professional associations, by the transfer of the

personnel, or by socialization, and thus promote the legitimation of their own organization as a "central organization" (DiMaggio & Powell, 1983). In this regard, some organizations embrace the role of translators for new ideas as part of their activities, bridging the gap between existing institutionalized actions and new, emerging concepts. The development of "master-ideas" is inevitable once the new concept or paradigm had been accepted and legitimized. Czarniawska and Joerges (1996) also point out the detrimental effect of some paradigms that stifle alternative or innovative ideas.

Discursive Model of Institutionalization of Organizational Practices

Phillips et al (2004) argue that institutions and institutionalization "can be understood as products of the discursive activity that influences actions" (p. 635). The discursive model of institutionalization highlights the role of creating and distributing written texts that become "edited" through their different contexts and through re-telling by various organizational actors (Czarniawska & Joerges, 1996; Phillips, et al., 2004). The concept of "editing" is understood as a process of interpretation and co-construction of ideas. Apart from texts, language, and graphic images, discourse is another way of developing and normalizing ideas and concepts that are vital to the institutionalization of organizational practices (Czarniawska & Joerges, 1996). These different organizational fields become part of the isomorphic processes described by DiMaggio and Powell (1983) as coercive, normative, and mimetic. In the process of institutionalization through discourse, normative isomorphism has prevailed and takes place in the form of

educational and training activities, including the production of reports, books, and other texts (Phillips et al., 2004).

Phillips et al (2004) elaborated on discursive analysis of the institutionalization of organizational practices and arrived at the following five conclusions. First, the accumulation of texts such as professional manuals, annual reports and academic texts help explain, promote, legitimize, and validate institutionalization of new practices. Second, discourses evolve progressively from a local to a global level. Third, texts become embedded in new discourses if translated by social actors that have central position among other actors and can use more coercive mechanisms. Fourth, organizational actors often draw on discourses from similar fields or are influenced by society to produce new institutions and de-institutionalize the existing ones. Lastly, the movement of genres between organizations increases the likelihood of the text will become embedded in new discourse. Studying the link between discourses and institutions became an important part of neo-institutional theory since it provides insight into emergence of new institutions. At the same time, this link highlights the role of social actors and the texts they produce and distribute contributing to our understanding of institutional entrepreneurship (Maguire & Hardy, 2006). Phillips et al. (2004) underscore the importance of successful institutional entrepreneurs when the texts they produce become part of central discourses in the field.

In the previous sections, I reviewed the tenets of institutionalism that have helped to define the neo-institutional school and also attended to organizations in

general. Since this study has been conducted in a mental health and addiction service organization, I reviewed the aspects of new institutionalism as they specifically apply to human service organizations. Following this section, I will focus on the nuances of mental health and addiction treatment services pertaining to neo-institutional theory of organizations.

3.6 Specifics of Human Service Organizations

Problems regarding the legitimacy of human service organizations and the existence of "moral work"[3] have been addressed particularly by Hasenfeld (1985; 1992a; 1992b; 2000a; 2000b) who calls for the adaptation of organizational theories to the specific conditions of human service organizations. The organizational inquiry within a social work perspective is based on the assumption that the principal function of human service organizations is to help to protect and maintain the personal well-being of the people using their services. This usually occurs by shaping or altering people's personal qualities and transforming them into desirable "final products" (Hasenfeld, 1985; 1992a; 2000a). Accordingly, human service organizations, especially those that aim to modify human behaviour, engage in moral work and reinforce moral values that are part of the environment from which they derive their legitimacy. Simply put, human service organizations are influenced by their clientele and vice versa. As Hasenfeld (2000a) reports, a series of moral assumptions about people who use

[3] Hasenfeld (1992a; 1992b, 2000a, 2000b) defines moral work as the type of work where the actors involved and the nature of the labour is imbued with values about peoples' social worth.

human service organizations are usually present and are expressed in organizational forms and practices. Basic moral assumptions are applied to the social worth of clients or patients: ascription of responsibility, amenability to change, desired outcomes, and categorizing a person either as an object or a subject. Organizations are more likely to become client-centred and highly committed if the clients are recognized as individuals with high social worth.

Hasenfeld (2000b) reports four main sources of institutional moral rules which are present on macro and micro levels. Certain rules emanate from powerful interest groups that have the potential to influence social policies and government decisions. The government itself can function as a powerful interest group, promoting rules based on its ideological, political, and economic positions. The community also provides a source for institutional moral rules and defines the local input on moral assumptions used in service delivery systems. This occurs as a result of the resistance from upper-level politicians to define sensitive issues, especially in cases with controversial and ambiguous moral rules. This also occurs because organizations reflect the moral values of environments in which they are embedded. Hasenfeld (2000b) asserts that a third source of moral rules is the organization itself. Organizational ideology is expressed in service goals, interaction with clients, and the participation of clients in governance of organizations or, conversely, their exclusion from activities that would shape how services are delivered. The moral assumptions that help form organizations and their structures can serve as a source of new institutionalized rules which, if supported by other similar organizations, can then influence social legislation and

policy measures. Coalitions between similar organizations and organized groups formed by clients with an ongoing mandate of advocating for change are one example of this process (Hasenfeld, 2000a; 2000b). Organizational forms and practices reflecting moral assumptions have a direct influence on how clients are treated. Although these assumptions might be reinforced by beliefs in technical rationality and efficiency, they are important factors in shaping the perception of clients' social value. Professionals working in organizations are a more formal source of moral rules. As each individual constructs his or her own reality based on interactions with the social environment, workers engage in moral work as they interpret already established rules or create new ones (Hasenfeld, 2000b).

One specific characteristic of human service organizations is their ability to function in the unstable environments from which they derive their legitimacy. Operating with indeterminate technologies and a lack of systematic or comprehensive knowledge brings an additional source of uncertainty, as it would in any organization system. To adapt to these conditions, it is necessary to implement more elaborate ideologies and to undergo organizational changes. Organizations then form loosely coupled structures and define ambiguous or even conflicting goals (D'Aunno & Vaughn, 1995; Hasenfeld, 1985; 1992a; Scott, 1986). Since ideologies used in mental health services cannot substitute technologies that professionals require in the field, several strategies have been developed and implemented, such as the introduction of different treatment goals. For example, the concept that emerged promoting controlled alcohol consumption for individuals with low to moderate risk based on the harm

reduction paradigm replaced the formerly prevailing view of total abstinence as the only possible goal (Health Canada, 2001).

The multiplicity of goals that dominate organizations serving heterogeneous populations with recurring conditions is a logical attribute of a human service organization that performs multiple activities for a variety of reasons (Hasenfeld, 1985; 1992a). Publicly funded human service organizations have their goals assigned to them by funding sources and legislative bodies. The funding sources define goals regarded as vital to achieving and developing an external evaluation and for monitoring these organizations' eligibility to obtain financial support. Nevertheless, the evaluation of an organization's performance has high ceremonial value and helps to demonstrate the social adaptation of an organization to its institutional environment (Meyer & Rowan, 1977).

Treatment Ideologies

Teresa Scheid asserts that treatment ideologies, an integral part of mental health organizations, guide the delivery of services (Scheid, 2004). Different treatment ideologies and organizational cultures can, according to Hasenfeld (1992a), Scheid (1994, 2004), and Scheid & Greenley (1997), often lead to ambiguous organizational goals and inter-professional conflict. To address the latter, organizations often engage in the homogenization of treatment ideologies in order to reconcile conflicting institutional demands and to better establish their roles as service providers (Scheid, 1994, 2004). To address the former, organizations form "loosely coupled" structures (Meyer & Rowan, 1977/1991)

that lead to ceremonial adaptation to their institutional environment accompanied by evasion of measuring organizational performance.

The adoption of distinct treatment ideologies results in modifications to treatment interventions that, in turn, have an impact on the treatment outcomes and general effectiveness of care (Scheid, 1994; 2004). Treatment ideologies framed by institutional demands and societal expectations change in relation to variations in the institutional environment. An example of this is community-based treatment services that have evolved as a result of society's altered perception of mental health and addiction problems, the civil rights movement, rationalization of services, and evidence from empirically based studies (Annis, 1984; Edwards & Guthrie, 1966; 1967; Edwards, Orford, Egert, Guthrie, Hensman, Mitcheson, et al. 1977).

On the micro level, professionals are shaped by the organization in which they work and vice versa. Although an ideology of care can not be reduced to the individual views and experiences of clinical workers, their personal belief systems influence their preferences to certain treatment philosophies and are a central aspect of the clinician-client relationship (Scheid, 2004; Hasenfeld, 2000b). Scheid (2004) further asserts that professionals incline toward certain treatment ideologies from professional training, clinical experiences, and professional socialization. At the same time, treatment ideologies serve as a means of legitimizing the activities that organizations provide and are a central feature of organizational culture. Since treatment ideologies in organizations are being constantly shaped and re-shaped, they become a source of organizational

change. They can "protect" organizations from modifications of therapeutic practices introduced by clinicians' individual beliefs and professional orientations and simultaneously help form the new developments and changes in the institutional environment (Thompson, 1980, quoted by Scheid, 2004).

Application of Neo-institutional Theory to the Mental Health and Addiction Sectors

Unlike organizations embedded in technical environments, mental health and addiction services are heavily influenced by their institutional environments. This includes continually changing perceptions of mental health and addictions among the general public that reflect the prevailing value systems. It is important to consider the relationship between professionally generated norms and the role that these norms play in provider-client relationships in the organizational context of provided care. This institutional environment has bearing on the functionality of that care, particularly by affecting financial support and by dictating the treatment of mental health (Scheid, 2004).

D'Aunno, Sutton and Price (1991) report the existence of multiple and uncoordinated sources of legitimacy in mental health and drug abuse treatment. Both sectors form complex networks among state and federal agencies, professional associations, advocacy groups, and licensing and funding groups. Rationalized myths and strong ideologies are the partial result of a lack of technology and a coherent body of knowledge (D'Aunno, Sutton & Price, 1991). In these particular working environments, the beliefs of the staff are more

influential than technology. Moreover, both sectors operate with conflicting beliefs that are in a constant state of evolution.

D'Aunno and Price (1985) report that the adaptation of mental health organizations and substance use treatment services to their environmental conditions has an influence on employment policy. Changes in this area involve the hiring of professionals with certain credentials who can contribute to or help to maintain the established organizational ideology; both workers and their ideologies thus play an important role in selecting treatment approaches.

3.7 Implications of the Conceptual Framework to Social Work Practice

The review of organizational literature in this chapter informs a broad understanding of the dynamics of the institutional processes of organizations. The important turning point in organizational inquiry in social work is represented by the incorporation of neo-institutional theory to human service organizations as developed by Hasenfeld (1972; 1985; 1992a; 1992b; 2000a; 2000b). Identifying the distinguishing qualities of human service organizations and developing specific concepts such as "clients as raw material", "goal ambiguity", "indeterminate technologies" or "moral work" provided the terminology needed to understand specific organizational changes in human service organizations (Hasenfeld, 1985; 1992a; 1992b; 2000a, 200b).

In the specific case of health and social services, the interplay between political and institutional forces has been accentuated. Although these external

forces are very relevant to the analysis and interpretation of my findings, I concur with Hasenfeld (1992a) that helping professionals, including social workers, are important in shaping micro-level processes that bring organizational change. In this regard, leadership, inter-professional relationships, and individually informed belief systems are crucial in defining and implementing these services. The neo-institutional theory as it has been adapted to human service organizations provides critical insight into the individual actions of clinical personnel as subjective but often powerful forces behind organizational change. As social workers view social problems in their broader context, so does this theoretical concept by linking the macro-level forces of political and administrative factors with micro-level processes of individual beliefs and motivations and then by qualifying their mutual relationship.

One of the shortcomings of this theoretical approach, however, is that in neo-institutional theory, the conflicts of interest within and between organizations have been downplayed by focusing upon organizations developing elaborate administrative structures (Scott & Meyer, 1991). Adapting this framework to the social work understanding of organizations, I recognize an implicit power aspect to theories of institutionalization for organizational change. Power is complex, fluctuating, and omnipresent in various relationships among external forces such as policies, funding, bureaucratic measures, and individual relationships between professionals and clients (Foucault, 1983). The explicit analysis of these dynamics power relationships is, however, beyond the scope of this study.

We have gained important insights into the interrelationship between macro and micro foundations of institutional processes through the recent developments in organizational studies on discourse analysis (Maguire & Hardy, 2006; Phillips et al., 2004), and through the concept of "translation" of organizational change by various "editors" (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996). "Translation" and "editing" acknowledge the role of individual actors including clinical practitioners in the institutionalization process. Thus, the developed institutional rules can be understood as negotiations between different professional groups necessitating coalitions and negotiations (Hasenfeld, 1992a).

3.8 Concluding Remarks

In this chapter, I reviewed the literature that helped understand neo-institutional concepts of organizational changes in general and in relation to mental health and addiction sectors in particular. Neo-institutional theory has been successfully adapted to human service organizations' particular attributes. This development is partially the result of the elaboration of concepts outlining the interrelationship between organizational context and particular normative and structural issues that are unique to human service organizations. In this regard, the problems identified thus far with the treatment of co-occurring mental health and addiction problems are associated with the artificial bureaucratic separation between mental health and substance abuse treatment services. Further, diverse

ideologies and philosophies leading to poor co-operation between different organizations are associated with different legitimizing processes for this population's services (Hasenfeld, 2000a; Mueser, et al., 2003). The utilization of neo-institutional theory as a framework for my study has facilitated and clarified the factors that are either easily overlooked or within the context of existing clinical research are not examined at all.

Chapter 4:

Research Design

Introduction

This chapter is organized into seven sections that discuss the key components of the research design employed in this study. In the first section I explain why case study, a common approach in qualitative organizational research, is appropriate for my study. The second section describes the two cases to be reviewed and outlines information on their immediate organizational context. In the third section, I provide an assessment of how the research methods were able to collect rich data and context-dependent information on the researched topic. Section four describes the challenges experienced during this data collection, including problems gaining access to the research site and the issues related to confidentiality. Section five focuses on the postmodern approaches to qualitative organizational research, including issues surrounding the dependability and confirmability of collected data. Section six focuses upon the techniques of data analysis, and finally concluding remarks are offered in the last section.

4.1 Case Study Research

In this research study, I employed a qualitative research design that accounted for the nature of the existing data and the absence of studies that either recognize the complexity of the examined topic or use the institutional theory of organizations. Therefore, the case study I conducted explored and uncovered new relationships from which I produced my interpretations of gathered data (Maxwell, 2005).

Case study is an important research approach to the development of many areas of social inquiry including sociology, psychology, and social work (Merriam, 1991). Although it has become a widely used research methodology in social science, some theorists are still offering new definitions of case study based on different paradigms, methodological preferences, or their professional orientation. For Stake (2000b), the case study is "a choice of what is to be studied" (p. 435). A case should be a complex unit, preferably contemporary, investigated in its natural context, using a variety of methods (Creswell, 1998; Merriam, 1991; Miles & Huberman, 1994; Stake, 1995; 2000b). These factors prompted me to select case study for my research because it allowed me to gather a broad range of information in context from multiple sources of data. Stake (2000a) emphasizes that one of the advantages of case study is that they are designed to bring out the viewpoint of the participants, thus "adding to existing experience and humanistic understanding" (p. 24). Experiencing the

activity occurring in its natural context and particular situations is integral to understanding the case's particular realities (Stake, 2006).

Case study is also inclined to using theoretical frameworks that guide research and data analysis rather than grounded theory that presupposes that theoretical perspectives will emerge from the data. Hartley (2004) asserts that the absence of theoretical concepts can lead a researcher to provide descriptions without meaning because a lack of prior understanding can lead to excessive research gathering and consequentially the researcher is then at risk of becoming disoriented with the data. It is important, however, that the researcher does not become in thrall to his/her theories, concepts, or specific knowledge of institutional conditions and is able to maintain a balanced approach to the data.

Orum and Feagin (1991) assert that ongoing processes observed by the researcher, either at the system or program level, allow one to "examine social action in its most complete form" (p.9) and ensures a detailed understanding of social and organizational processes in the organizational and environmental context. Lee (1999), who applies case study research to organizational research, states that case study is suited for examination of *why* and *how* contemporary, real-life organizational phenomena occur. At the same time, case study produces context-dependent knowledge which, according to Flyvbjerg (2004), is the only knowledge possible in human affairs. Tentative framework and rich data collection can change the perceptions and understanding of studied issues and theory might change during the research as a result of repetitive examination of the framework against the data (Hartley, 2004). These changes

require the researcher to reflect not only upon the theories that he/she uses, but also the emerging data.

I have used the holistic multiple case study design which has allowed me to examine the nature of my two cases on a more global level (Yin, 2003b); Yin believes that the holistic character of case study refers mainly to the selection and studying of a single unit of analysis without other subunits. Verschuren (2003) on the other hand, assumes holism means to "look at the whole object instead of at the object as a whole" (p.125), something that I have engaged in here. The holistic approach to research helps to avoid "tunnel vision" syndrome; the tendency to look at objects of research at one single point in time, detached from their political, social, and physical context. By avoiding this, holistic case study accounts for the interdependency between social context and studied phenomena (Verschuren, 2003). Given the complexity of the organizational environments of my two cases, I found case study very useful to draw out a comprehensive view of the problem. Stake (2000) identifies both *intrinsic* case study, undertaken to provide a better understanding of a particular case, and *instrumental* case study, providing insight into a particular issue or generalization by facilitating researchers' understanding. To define my case study, I blended both types of case study as Van Teeffelen, Bitar, and Al-Habash (2005) did with their work on studying youth resilience. Although I have an existing interest in the institutionalization of concurrent disorders phenomenon, I try to illustrate a more general point with this research.

Yin (1998) emphasizes the importance of a clearly defined case or unit of analysis and admits that rigidly delineated cases are unlikely to occur. The key characteristic of the case study design is that it allows the researcher to establish boundaries and contexts of a unit of analysis during the process of data collection. This strong advantage allowed me to study the phenomenon of treatment for concurrent disorders in its contextual conditions and further explore the phenomenon during the research process. For example, during the process of data collection, contextual conditions turned out to be integral to understanding the institutionalization of integrated treatment, and I was able to include them based on Yin's (1998) concept. For example, I included the Concurrent Disorders Capacity Building Team and its activities as part of my data collection once it became clear that this data represent an important part of the institutionalization of integrated treatment for micro programs within the organization and on a macro level in the community. Thus, my cases continued to evolve throughout the inquiry through an inductive and iterative process (Becker, 1992; Harding, Fox & Mehta, 2002). Ragin (1992), also partial to the inductive approach, argues that researchers might not know the exact nature of their cases until the research, including results, is completed. "What *it* is a *case of* will coalesce gradually, sometimes catalytically, and the final realization of the case's nature may be the most important part of the interaction between ideas and evidence" (Ragin, 1992, p. 6).

4.2 Research Site

In this section, I describe the cases in the study to introduce the reader to the units of analyses. Broader contextual factors, along with more details on the cases will be provided in Chapters 5 and 6 with my findings as they pertain to the institutionalization of integrated treatment.

The Centre for Addiction and Mental Health (CAMH) in Toronto was the research site of my study. The two focal cases were the Concurrent Disorders Service and the Problem Gambling Service, which are placed organizationally in the Addictions Program. From its website, CAMH is described as Canada's leading addiction and mental health teaching hospital; it is considered a model, progressive organization that applies the latest in scientific advances through clinical practice, health promotion, education, research, and policy development (www.camh.net). CAMH was formed in 1998 as a result of the merger of the Clarke Institute of Psychiatry, the Addiction Research Foundation, the Donwood Institute, and the Queen Street Mental Health Centre (Garfinkel, Simpson, & Baumann, 1999; www.camh.net). Detailed information on the merger will be provided in Chapters 5 and 6 with my findings.

Selection of the Cases

Ragin (1992) asserts that "[i]mplicit in most social scientific notions of case analysis is the idea that the objects of investigation are similar enough and separate enough to permit treating them as comparable instances of the same

general phenomenon" (p.1). The Concurrent Disorders Service is a service mandated to provide integrated treatment for individuals with concurrent disorders. The Problem Gambling Service provides outpatient services for individuals with gambling problems and their significant others. It closely co-operates with the Problem Gambling Project, a small program with its own manager and staff members. This program is mandated by the MoHLTC to *provide education and training activities to problem gambling counselors and* allied professionals across the province. Some of the staff members have been cross-appointed at both the Problem Gambling Service and the Problem Gambling Project working as trainers and therapists.

Both cases – the Concurrent Disorders Service and the Problem Gambling Service - are part of the organizational environment where other mandates such as education, research, health promotion, and public consultation are among their functional elements. At the same time, both programs function independently enough to be studied as two distinct entities, providing data related to the evolution and implementation of treatment services for the affected populations. This research design conforms to Stake's (2006) definition of a multi-case research study examining several (or at least two) cases linked together at sites that have a programmatic link. I have used these programs to explore and interpret the developmental processes of treatment for concurrent disorders or co-occurring mental health, substance use, and gambling problems by comparing them contextually and organizationally.

Case Description

Case A: The Concurrent Disorders Service evolved out of the addiction treatment service at the former ARF. The Concurrent Disorders Service provides outpatient services to clients who seek treatment for their substance use problems but are also experiencing mental health problems (Tsanos, 2005). Recently, as part of the redevelopment project of the Queen Street site, where all CAMH programs will eventually reside at one location, the Concurrent Disorders Service will have 12 beds in the residential Alternate Milieu Unit (Functional Program, Addendum, Revised December 13, 2006). During the data collection, the inpatient part of the Concurrent Disorders Service was only in the planning stage and not yet operational. The services at the Concurrent Disorders Service include comprehensive psychiatric assessment, treatment planning and group preparation, individual and group therapy, case management, and pharmacotherapy.

The most prevalent disorders among the clients seeking treatment at the Concurrent Disorders Service in 2000 were co-occurring mood disorders followed by anxiety disorders. From Axis II disorders among CDS clients (2000), borderline personality disorders represent the most prevalent group (Tsanos, 2005). There are three specialty programs/clinics in the CDS:

- The Integrative Group Therapy Clinic (IGT) focuses on delivering group therapies to individuals who experience co-occurring severe and persistent mental health and addiction problems in a variety of group therapy formats. Clients are expected to make a 6-month commitment to participate in

treatment. This clinic serves a relatively heterogenous and comorbid group of clients and attempts to offer a variety of treatment goals.

- The Borderline Personality Disorder Clinic (BPD) in its current form is a result of the integration of the former Personal Disorder Clinic at QSMHC and the Dialectical Behavior Therapy Clinic of the former ARF. Treatment at this clinic is provided using Dialectical Behavior Therapy in intensive outpatient model including educational support groups for family members. The clinic also provides consultation (one time opinion on diagnosis and medication) as well as training and educational activities for professionals in the community.
- The Eating Disorders and Addiction Clinic (EDA) focuses on individual and group therapies for male and female clients who experience concurrent substance use and eating disorders.

I have also included an additional programmatic structure in this case study. The Concurrent Disorder Consultation Liaison and Access Service consist of an interdisciplinary team that assists with concurrent disorders capacity building within CAMH and across the province. This organizational part of CDS came to my attention during my case study's data collection stage and felt it was important to include in my analysis.

Case B: the Problem Gambling Service focuses upon the treatment of problem gambling and along with the Problem Gambling Project is responsible for education and training funded directly from MoHLTC. Although the Problem

Gambling Service does not have a specific mandate to provide integrated care, an increasing number of studies showing a high overlap of problem gambling, substance use, and mental health problems are circulating among organizational discourse (Hodgins, Peden, & Cassidy, 2005; Shaffer & Korn, 2002; Rush, et al., 2008b). My rationale for including the Problem Gambling Service was the assumption that it works with a clinical population that has complex needs related to comorbidity. This is also supported by the conceptual theoretical „pathways" model of gambling (Blaszczynski & Nower, 2002). In pathway 2, gambling problems are related to underlying emotional problems including anxiety and/or depression, poor coping skills, and problem solving skills. In pathway 3, the underlying problems include impulsivity and antisocial behavior. The increasing interest in issues related to co-occurring gambling and mental health problems or other addictions provided a good comparative environment for comparing actual clinical practices in these two settings. I also compared institutionalized responses of the gambling sector to the rationalized myth of integrated treatment. This dissertation research has itself become part of the institutionalization of problem gambling and co-occurring mental health and substance use problems because of the support from the Ontario Problem Gambling Research Center as it attempts to attract more researchers into the field. Tables 4.1 and 4.2 illustrate the organizational structure of CAMH and of the Addictions Program respectively. Table 4.3 illustrates the structure of my two cases.

Table 4.1 Organizational Structure of CAMH (October 2007)

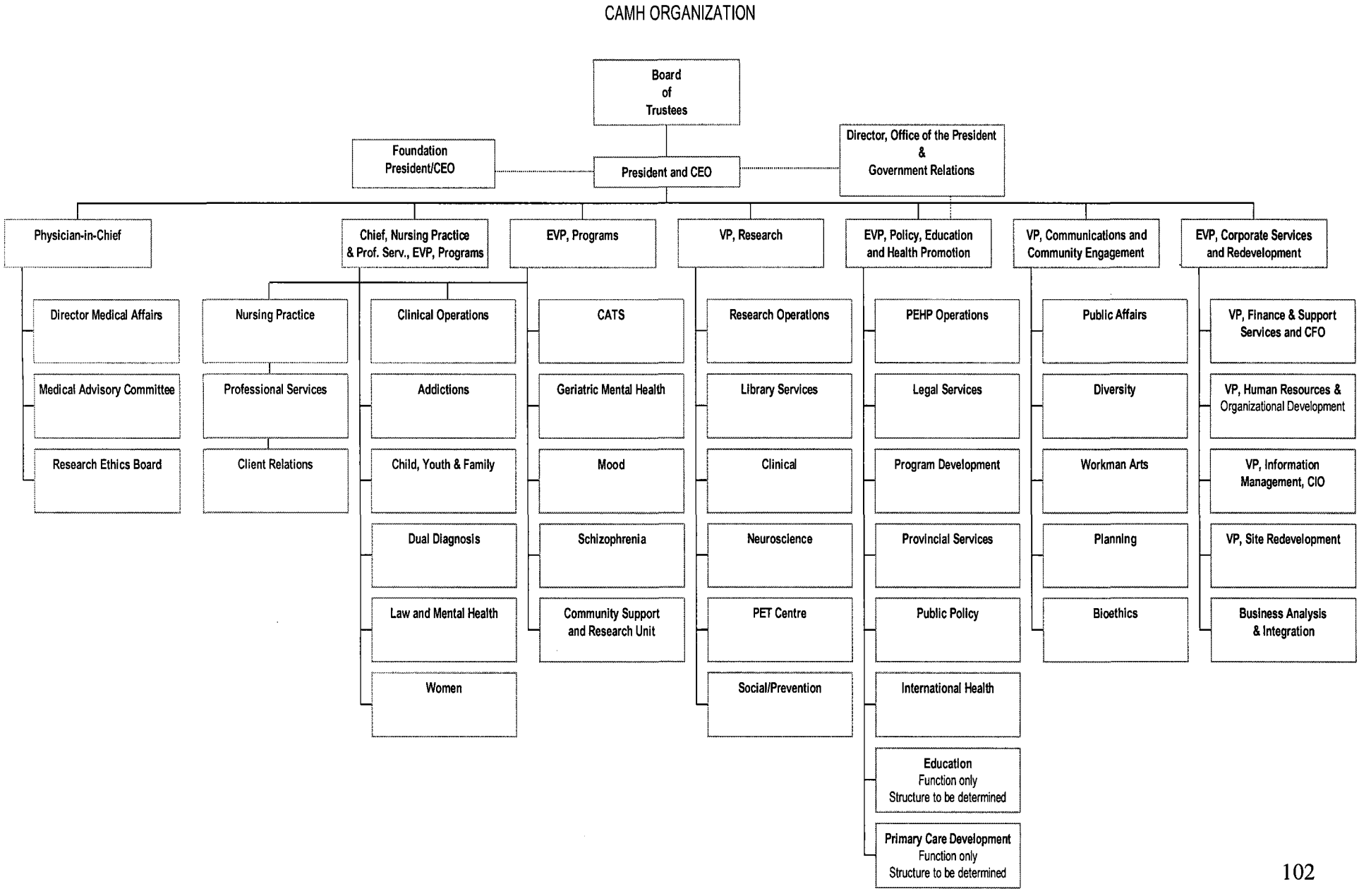


Table 4.2 Organizational Structure of the Addiction Program

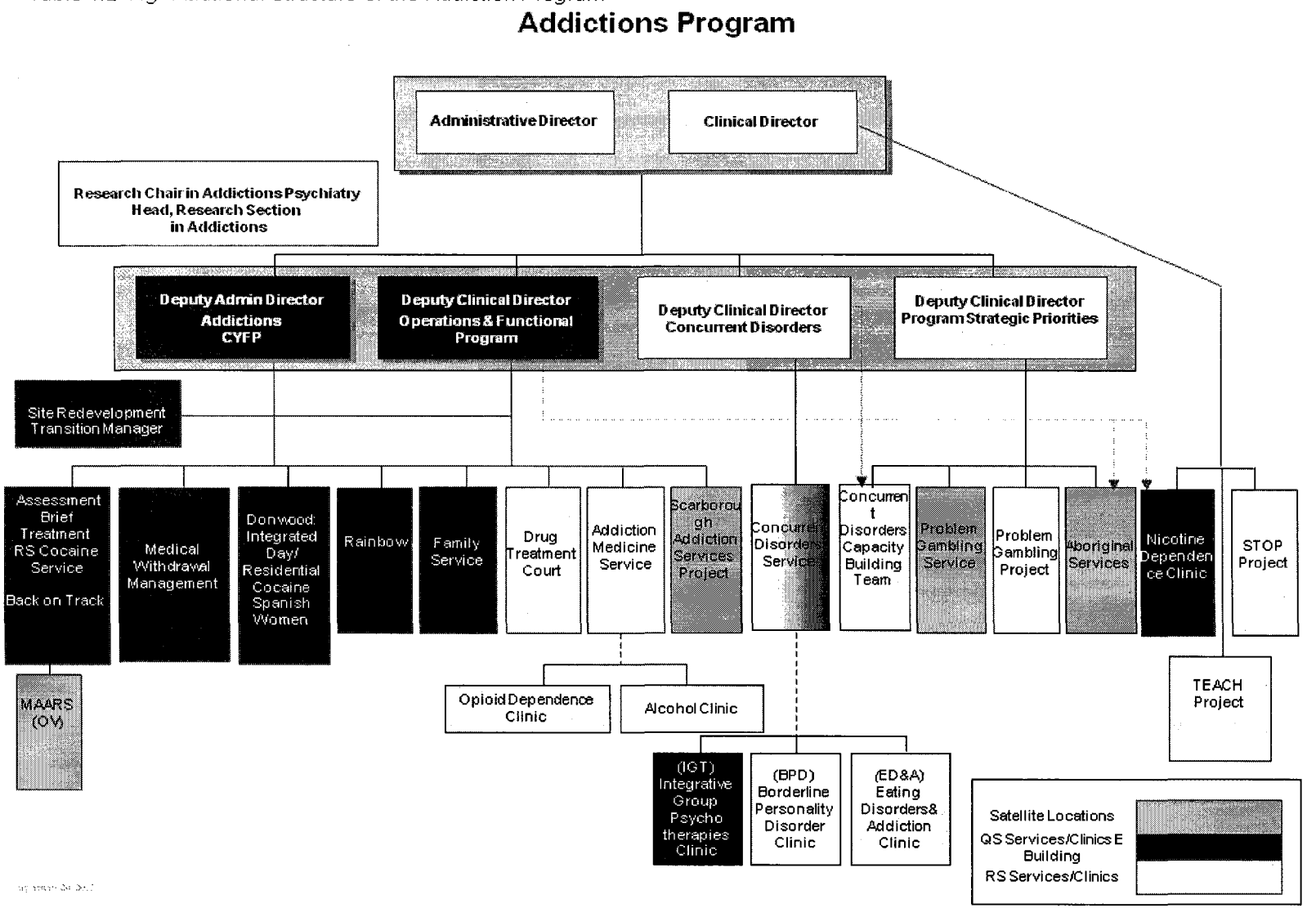
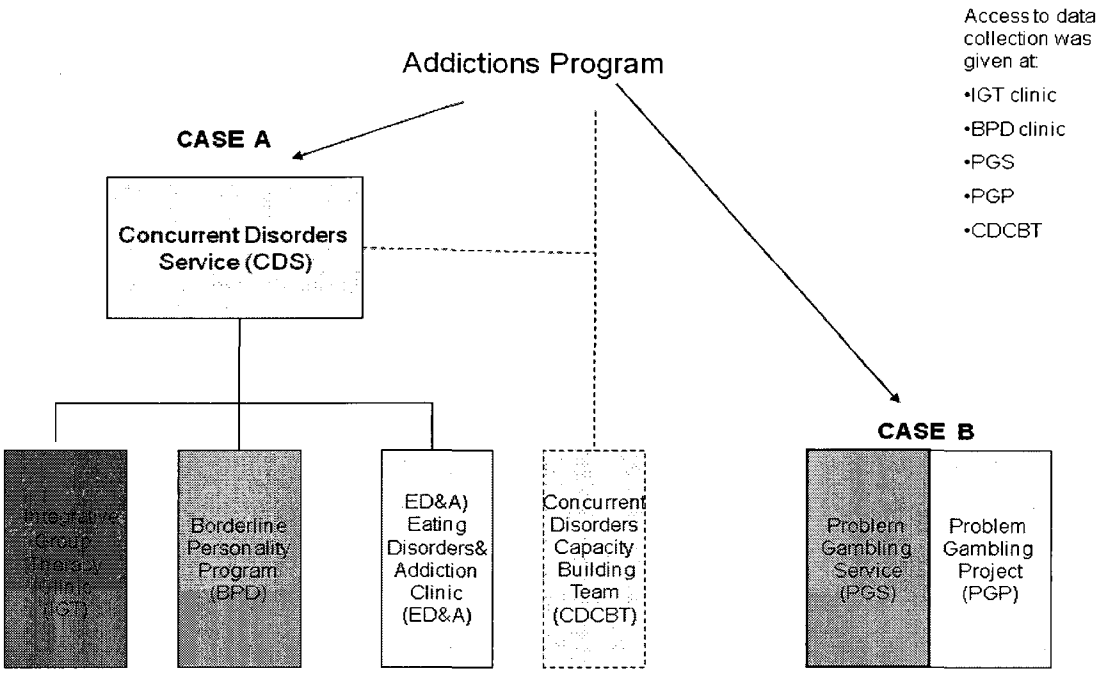


Table 4.3 Organizational Chart with Cases



Selecting these specific programs complies with the concept of purposeful and strategic selection of cases aimed at an exploration of the studied topic. The selected programs are part of the larger institution that has a formal commitment to the integration of mental health and addiction treatment services. At the same time, the programs are unique sites of practice that focus on particular strategies and responses for dealing with diverse service users with complex needs.

4.3 Methods of Data Collection

The primary sources for data collection in my research were policy documents, clinical guidelines, interviews with members of multidisciplinary teams, program managers, clients' groups, significant others, and observations of administrative and clinical meetings and related events. The variety of data in my exploratory case study research prompted me to make an initial plan for data collection as advised by Hartley (2004) and Yin (2003b). The tentative research plan helped me organize the first steps towards finding relevant sources of information and proceed from general to more specific information.

First, I reviewed policy documents and reports (Table 5.1 in Chapter 5) to gain an understanding about the institutional environment of both cases. The second step was to collect information and gathered data about the structure and functioning of the Concurrent Disorders Service and the Problem Gambling Service within CAMH and in the community. I also attempted to observe meetings at both programs in addition to conducting interviews to further narrow the scope of my research.

Interviews

The use of interviews in my study provided information that could not be directly observed or studied in documents; interviews can illuminate feelings, thoughts, perceptions, and interpretations of the surrounding world as well as the

intentions of individual actions (Creswell, 1998; Merriam, 1991). I used semi-structured interviews, which proved to be very useful to obtain certain information from all interviewees. Semi-structured interviews allowed a balance of free-flowing and directed conversation to be maintained (Lee, 1999; Merriam, 1991). I posed pre-planned questions regarding the evolution and implementation of integrated treatment to each participant (these questions are included in Appendix A). I also took the liberty of modifying interview questions to approach the different professional or personal backgrounds of interviewed participants.

Interviews also helped me to focus my observations during the clinical meetings on issues that were raised to determine discrepancies between rhetoric and real practice. I interviewed representatives from different professional groups including social workers, psychiatrists, psychologists, nurses, and assessment workers. In addition, I interviewed researchers and members of middle and upper management, including the executive level, and external stakeholders, particularly experts and policymakers involved in the formulation and planning of policy measures. Some of the individuals that I interviewed had been known to me either as researchers, experts, or public activists while some of them were "discovered" during the data collection or recommended by other participants (the list of participants identified by their job positions is included in Appendix B).

The collection of data became more opportunistic as research proceeded towards more specific information; the research was guided by new questions that evolved from information already gathered (Hartley, 2004; Maxwell, 2005;

Miles & Huberman, 1994). During data collection, I approached people with different viewpoints and explanations and also engaged in informal conversations with personnel after the meetings or at informal gatherings to round and balance the data obtained.

Document Analysis

Documentary information helped me corroborate and augment evidence from other sources. Aside from verifying information including organizational structure, names, job positions of staff members, and internal memos, official political documents provided information on politically influenced directives for proposed measures at the system or program level. CAMH is involved in public policy development and advocacy through its staff members, clients, and family members. At the same time, the organizational functioning of the institution and that of the two focal programs has likely been influenced by these policy measures. Therefore, I reviewed mission statements, annual reports, staff policies, treatment standards and noted how documents were mirrored in actual practice and how they generally affected the planning of integrated treatment for concurrent disorders (Appendix C – the list of key organizational documents, reviewed).

Participant Observations

Observations, though limited due to challenges in obtaining consent from research participants, were also utilized where possible; these allowed me to

better understand the whole atmosphere and dynamic of the work setting. I am aware that data collection by using observational means employs highly subjective human perception and I recorded observed information in the form of field notes including detailed descriptions of my personal reactions and thoughts related to the observed events.

As Hartley (2004) and Merriam (1991) assert, in addition to interviews, observations are the primary source of data in organizational research and case study research. These usually also include informal interviews and conversations that have the great advantage to act as an observer and notice the phenomena that might not seem relevant to a participant. Although I was not able to observe meetings at some of the clinics at the Concurrent Disorders Service, the process of gaining official access to the site and participants' cooperation was still part of the data collection experience that informed these research findings.

Focus Groups

In my research proposal, I intended to use focus groups at the end of the data collection process as a means to supplement the preliminary research results and tentative conclusions with reinforcing feedback. This method has been considered useful for encouraging discussion and allowing the expression of different opinions and points of view (Lee, 1999; Marshall, 2006). However, after encountering apprehension from the participating staff about the preservation of confidentiality, I decided to obtain feedback on my interpretations

of the data by talking to the research participants individually, particularly those who were interviewed initially.

4.4 Gaining Access to the Programs

CAMH has been very active in conducting research studies, partly because of its affiliation with the University of Toronto; however, it is more readily accepting of clinical trials and experimental design rather than organizational research. Gaining access to the programs was my primary concern since I was aware that staff of both programs could feel that my presence interfered with their work routines. Secondly, staff in addiction and mental health services are regularly functioning in a busy, high-stress environment that is not conducive to extended interruptions by even the most earnest researcher. This can lead to unease on the part of staff about formally identifying themselves to the researcher. Finally, the researcher's findings might reveal working practices that are not compatible with the public's perceptions about the nature of their services.

With all these potential obstacles in mind, I was hopeful that since I had completed my PhD practicum at CAMH, I would be able to access the research sources needed, as I had become more familiar with staff, clinicians, and program managers. Secondly, as a former addictions counselor in a centre with a research mandate, I believed I could more effectively relate to the ongoing work at CAMH and recognize when my presence was distracting. Moreover, I

designed this study to be less intrusive for clients or staff members than most experimental studies conducted in health settings/human service organizations.

Part of the formal procedure to gain access and conduct research on the programs includes an approval by the CAMH Research Ethics Board. Following the WLU Research Ethics Board approval, I sought approval from the CAMH REB. My application for an expedited review was dismissed and the proposal instead went through a full ethics review. Throughout this process, I experienced the practical functionality of an unconventional research design that can be challenged on the merits of its credibility and validity. Lincoln and Tierney (2004) state that critical, postmodern, or action oriented research can undergo endless revisions as institutional research ethics boards seek to streamline proposals along more conventional lines. These revisions to my research proposal and the actual approval timeframe significantly delayed the start of data collection. Once the approval had been granted, I was able to approach CAMH staff through formal channels in the person of my Research Practicum Advisor at CAMH in the summer of 2004.

After the CAMH REB granted me formal access, I was introduced to program managers who facilitated the presentation of my research proposal to clinical staff. I approached prospective study informants at these meetings and asked them to participate in semi-structured interviews (Interview informed consent letter forms are in Appendix D, E). I also asked for consent to observe clinical and administrative meetings. I was permitted to attend staff meetings at the Borderline Personality Disorder clinic, part of the Concurrent Disorders

Service, and at the Problem Gambling Service. Monthly meetings at the Problem Gambling Project were also made accessible to me as were the business biweekly meetings at the Borderline Personality Disorder clinic, which I attended from February to August 2008. However, the staff of the Borderline Personality Clinic did not consent to have me attend their clinical meetings since these were reserved to discuss client-therapist dynamics of the therapeutic process and the stresses that could result for both client and therapist there from. Confidentiality and a comfortable sharing environment superseded my research aims.

I was given access to as many weekly clinical and administrative meetings at the Problem Gambling Service as needed, and I divided my time between meetings at both programs. I availed myself of webinars, research meetings, addiction rounds, and other training events that were generally accessible to all CAMH staff. I also attended CAMH events in the community, including a meeting at a Toronto Central Local Health Integration Networks (LHINs).

Out of three clinics that were part of the Concurrent Disorders Service, I was granted limited access to the Borderline Personality Disorder clinic to attend biweekly administrative meetings but not clinical meetings; instead, I interviewed some of the clinic members outside of clinical meetings. The team at the Integrated Group Therapy clinic did not consent to have their meetings observed over concerns of confidentiality, but in two cases I successfully interviewed members of the team individually. I was not able to contact the manager of the Eating Disorders and Addiction clinic to request access; our scheduled meetings were always postponed or cancelled. After several unsuccessful attempts to

speak to the clinic manager, I instead tried an alternative route by recruiting staff from clinics where I had gained access. Despite the options of off-site staff interviews or my pledge not to make any audio recordings, some of the participants felt that their identities would still not be secure, given the specifics relating to populations they were serving and treatment services they were providing. In addition, some staff may have perceived my work to be a CAMH study rather than a research study conducted to fulfill criteria for a PhD degree; I hypothesize that this was due to the formal requirement for student research to have a CAMH staff member as the principal investigator of the study. This reluctance to participate in the research study indicates the workers' concern over potentially negative consequences for their participation if the study results should be made public. Although my access to some clinics limited the depth of my investigation, I was able to compensate with more participant interviews than originally planned; I conducted interviews with 21 individuals involved in the research, planning, or delivery of services for people with concurrent disorders, as well as service users and their family members, for a total of 27.

I was allowed to recruit clients and family members participating in both programs by soliciting through flyers approved by the CAMH REB and displayed at designated locations. Out of 9 clients that responded to the recruitment flyers, 6 were eligible to participate including 2 family members. The sole criterium for participation were experiences with integrated care at one of the studied programs.

I also analyzed the content of the available policy and organizational documents through CAMH's intranet and used reports, newsletters, and daily CAMH broadcasts as well as resources for professionals developed and disseminated by CAMH staff. I had limited access to internal letters or intra- and inter- organizational correspondence (meeting minutes, job descriptions, operating plans). Although access to the research site and recruitment of personnel were challenging at times, the rich data I have collected will better illuminate the dynamics of the organizational setting of both cases.

4.5 Addressing Validity and Reliability of Collected Data

Reliability and validity, often considered the remnants of positivist philosophies of science, remain controversial among qualitative researchers. More moderate views have since been embraced and require definition appropriate to their equivalents in qualitative inquiry (Lee, 1999; Lincoln & Guba, 1985, 2000; Marshall & Rossman, 2006, Maxwell, 2005). Lee (1999) emphasizes that the important issue of qualitative research in organizational studies is to use multiple data collection methods, thus creating a hybrid or combination of methods within a single study (Miles & Huberman, 1994; Patton, 2002; Yin, 2003b).

To ensure the quality of my research along these lines, I used different data sources, different data collection methods (documents, interviews, participant observations), and also obtained reinforcing feedback about the

preliminary findings from the key informants. Marshall and Rossman (2006), elaborating on the concept of the "truth value" of qualitative research (Lincoln & Guba, 1985), suggest criteria for this that can be evaluated on credibility/believability, transferability, replicability, and confirmability. The credibility of a qualitative study is the accurate and complete identification of the studied phenomenon. I enhanced my study's credibility by discussing major definitions and comprehension of the main themes of my study in conjunction with the research participants. Merriam (1991) recommends the clarification of investigators' positions through the identification of the basic assumptions and theories that inform the study and also the context from which data was collected. I concur with Marshall and Rossman's (2006) assertion that research can be credible only within the boundaries of the particular setting and concepts of that research since participants and researchers construct that reality.

My research design built upon the premise that our perception of reality is highly subjective, and everyone socially constructs his or her reality uniquely (Berger & Luckman, 1980). I have followed the ideas of Lincoln and Guba (2000), who acknowledge that the existence of created knowledge affects the interaction between and among the researcher and research participants. Patton (2002) and Maxwell (2006) also emphasize the "multidimensional" and "interactive" nature of interpretation and the influence of the researcher's professional background, experiences, world views, and personal beliefs. Conscious of these potential pitfalls, the design of my research adequately counters over-subjective conclusions and grounds my findings behind current social work perspectives.

Buchanan and Dawson (2002) state that organizational changes can be absorbed through personal narratives and interpretation, dependent on participants' backgrounds and different ways of meaning-making.These ways of meaning-making can differ due to partial knowledge or advancing personal or political agendas of both participants and researchers. The collected data can thereby reveal competing accounts of events. In this study, I viewed all the collected data as equally important and included them into through a subjective and selective lens which is tempered by the conceptual framework I have employed.

4.6 Managing Data Collection and Data Analysis

The analysis of the collected data was guided by the following research questions:

1. What factors are present in the processes of the institutionalization of integrated treatment of concurrent disorders and/or gambling problems in Ontario?
2. In what ways are these factors interrelated?

To answer these questions, I have focused on exploring the following factors that are associated with organizational changes on both macro and micro levels:

- The interrelationship between the changes in programs' institutional environments and the processes leading to organizational adaptation within those environments
- The institutional processes that create organizational norms, routines, and procedures that, in turn, develop integrated treatment for people with concurrent disorders
- *Organizational adaptation to institutional environment as reflected in* changes in organization structures, technology, and ideology
- The role of organizational discourse in the process of institutionalizing integrated treatment
- The ways individual beliefs, values, along with professional background shape the development and organization of integrated treatment provided to clients with concurrent disorders.

With qualitative research, data collection and analysis is a simultaneous process carried out in an open-ended way (Creswell, 1998; Hartley, 2004; Lincoln & Guba, 1985, 2000; Marshall & Rossman, 2006; Maxwell, 2005; Merriam, 1991; Miles & Huberman, 1994). Therefore, my data analysis practically began in the field, forming an iterative relationship with document analysis, interviews, and observations. By beginning this interpretation and analysis during my field research, I could constantly compare the value of emerging categories for sorting the collected data. At the same time, it provided an opportunity to share and confirm my findings and subsequent interpretations with

participants in the case study as advised by Hartley (2004) and Miles and Huberman (1994).

Marshall and Rossman (2006) and Miles and Huberman (1994) also suggest combining the initial transcription of collected data with ongoing or early analysis. This helps the researcher gain insights and plan strategies for collecting new, often better, or more relevant data. Patterns and categories that emerge from previously studied literature or collected data can help plan further data collection to fill gaps existing in the preliminary research. I have used this technique to increase the efficiency of my data analysis and to avoid being overwhelmed by data in the later stages of my research (Miles & Huberman, 1994; Wolcott, 1994). The analysis was then guided by my conceptual framework and my knowledge of the studied phenomena (Marshall & Rossman, 2006).

I transcribed all but three of the audiotaped interviews[4], which encouraged a more intense and introspective review. Content analysis of policy documents and other texts was also conducted to look for emerging themes. Some of the documents and all interviews were analyzed using NVivo7. The coding of data was oriented by organizing the data around conceptual categories (e.g. mechanisms of isomorphic change, data regarding institutional entrepreneurship, etc.). During the process of collection and analysis, the data led me to explore microprocesses in different components of the institutionalization of integrated treatment, which then prompted me to add additional literature to the interpretation of my findings. In this way, I understood the intricacies of the institutionalization of an integrated treatment paradigm and now see

[4] For lack of time, I hired a transcriber.

organizational change as a non-linear process co-constructed by various social actors.

During the data analysis, I incorporated Marshall and Rossman's (2006) analytic procedure entailing the organization of data, immersion in the data, generating categories and themes, coding data, and data reduction and interpretation. Data collection and analysis as an ongoing process can have an indefinite character so Lincoln and Guba's (1985) suggest theoretical guidelines about where to end the study. After the exhaustion of resources and the saturation of categories through continuous data collection that start to identify certain patterns, but no new information, a study should be concluded. Patton (2002) also notes that part of the challenge of qualitative research and analysis is that, given the amount of data available, there are no exact rules, formulas, or tests that can be generally or universally applied. The human factor is both the strength and weakness of qualitative research and the only rule that should apply is: "Do your very best with your full intellect to fairly represent the data and communicate what the data reveal given the purpose of the study" (Patton, 2002, p. 276).

To conclude this section, I am aware that case study has enormous potential to provide different interpretations of data. For example Teram (in press a) states that when analyzing case study, "researchers have to determine their analytical focus and present their data in a way that facilitates the most persuasive presentation of their argument. In this process they cannot always use all the analytical opportunities provided by the data" (p. 1). Building on his

premise, the collected data can be re-analyzed in the future to offer an alternative view or to expand the existing theoretical framework. My data therefore is a potential source of new analytical and conceptual opportunities that can build on current analysis as well as on a revision or critique of the analysis provided in this thesis.

4.7 Concluding Remarks

In this chapter, I outlined the methodological choices made in developing the research design, conducting the data collection, and analysis of this study. Case study has proven to be a very good structural choice to explore this topic and have provided me with the flexibility to adapt to aspects of organizational research that were beyond my control. In fact, the most challenging part of this process was gaining formal access to a research site and having participants' assistance during the data collection. This important experience has prompted me to read and learn more about organizations and the challenges researchers encounter when studying them. At the same time, it has also become part of the organizational context by providing useful information on the dynamics of the research site and helping to clarify the implications of the data. In the next two chapters, I present the findings of my research study.

Chapter 5:

Institutional Context of Co-Occurring Mental Health and Addiction Problems

Introduction

In chapters 5 and 6, I will present the results of my research study as they pertain to the framework of institutional theory. I will support my arguments with data collected through interviews with 27 individuals involved in the research, planning, or delivery of services for people with concurrent disorders and problem gambling as well as service users and their family members. I will also excerpt my field notes and my analyses of relevant policy and organizational documents.

In this chapter, I offer a broader institutional context for my two cases by providing a review of national and provincial mental health, addiction, and gambling policies. I examine how the development and implementation of integrated treatment for concurrent disorders has been affected by ideological, political, professional, and bureaucratic factors in both mental health and addiction sectors.

5.1 The National and Provincial Context of Mental Health and Addiction Services

The Canadian federal government is responsible for dealing with mental health and addictions on two fronts. First, it has a direct responsibility for specific groups of Canadians: military veterans and personnel, inmates of federal penitentiaries, the RCMP, Canadian First Nations people living on reservations and Inuit people. Second, it is responsible for providing a national perspective, vision, and strategy for dealing with mental health and addiction. This includes transferring funds to provincial governments for data collection, research, and drug approval processes (Kirby, 2004a).

In 2002, the Commission on the Future of Health Care in Canada led by Roy Romanow issued a report recognizing that the mental health system has long been an "orphan child" of Canada's health care system and stressing the importance of including mental health in overall health care reform. However, the Standing Senate Committee on Social Affairs, Science and Technology that was chaired by Senator Michael Kirby decided to follow its own national review of health care in Canada ("The Health of Canadians," The Federal Role, 2002) with the first national overview of mental health policies (Kirby, 2005).

The findings of Kirby's Committee reiterated that "the mental health and addiction system is not a real system in any recognizable sense of the term ... [but]... it is more of a complex of services ranging from acute care to support housing that have been delivered under different jurisdictions, NGOs, private

providers and peer support" (Kirby, 2005, p. S8). Although mental illness is prevalent in one in five Canadians in their lifetime, federal inaction in response to this statistic singles out Canada as the only developed country lacking a national action plan for mental health, mental illness, or addiction (Kirby, 2005).[5]

On the national level, a number of factors have made the search for a systemic consensus approach to mental health and addictions a challenging task. Such factors include the different approaches to mental health and addiction services that have evolved from variations in the historical development of Canadian regions, the diverse urban and rural life styles of certain communities, and the cultural diversity of the country itself (Rush, Fogg, Nadeau, & Furlong, 2008). Although the need for federal leadership in the development of a national mental heath and addiction plan is clearly needed (Hartford, et al., 2003; Kirby, 2005), Beausejour (2005) sees a single Canadian system as a utopian and ultimately ineffective concept. He instead calls for a "*network of systems* designed to reach common goals, standards, and results among all stakeholders" (emphasis by the author) (p. S30) without contrasting the mandates of federal, provincial, and territorial initiatives.

The main responsibility for planning and organizing the delivery of mental health and addiction services in Ontario rests with the provincial MoHLTC (Kirby, 2004a). Ontario's addiction services also receive funding from the federal government, the Ministry of Community and Social Services, the Ministry of Correctional Services, the United Way, its municipalities, and private donors.

[5] At the time of writing this thesis, the Mental Health Commission of Canada was carrying out the public consultation process on the newly developed framework for a mental health strategy for Canada.

This wide range of funding sources has made it extremely difficult to plan and coordinate services (Ontario Substance Abuse Bureau, 1999). The recent transformation of the health care system into a network of local health authorities with more control than the District Health Council system they replaced has been long awaited. As a result of provincial health care reform, newly established LHINs exercise their right to plan, coordinate, fund, and monitor the delivery of mental health and substance use services in the province (MoHLTC website).

An analysis of the institutional environment of mental health and addiction services in Ontario during three distinct time periods will show how the concept of integration of treatment for concurrent disorders has become institutionalized and how it has led to the current coordination challenges facing CAMH and the LHINs.

The first period concentrated on policy developments in mental health and addiction systems before and after the release of the Graham Report in 1988 (*Building Community Support for People: A Plan for Mental Health in Ontario*, 1998). This report observed specific factors related to changing perceptions of mental health and substance use in the late 1980s.

The second period bore witness to the restructuring and rationalization of mental health and addiction services to focus on outcomes and system accountability in the 1990s. During this time, the institutionalization of integration intensified and became a highly debated topic with little critical evaluation. Both cases under my study, the Concurrent Disorders Service and the Problem

Gambling Service, were established at this time as services embedded in the wider organizational context of the newly founded CAMH.

The third period began with the report *Best Practices: Concurrent Mental Health and Substance Use Disorders*, developed by the CAMH (Health Canada, 2001), and the *Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs* (2002). The recommendation for mental health reform in Ontario was prompted by a greater recognition of the needs of people with mental health and substance use problems from the first phase, previous efforts to provide some direction in numerous service integration attempts in the second phase, and by establishing better local governing structures in the provincial health care system in this third phase. The newly established LHINs that serve as regional governing bodies represent one of the many changes in the Ontario provincial system. At this same time, the first national review of the mental health and addiction system by the Kirby Committee released its reports (2004a; 2004b; 2004c; 2005) that acknowledged the detrimental effect of stigma on the experiences of people with mental health and substance use problems, and called for better national and provincial integration and coordination for both systems.

Table 5.1 provides an overview of the main turning points in the mental health and substance use sectors that represent the broader context for developing integrated treatment for concurrent disorders.

Table 5.1: Overview of main policy initiatives

Time Period	Mental health policy	Addictions policy	Gambling policy
1950 - 1970	○ Mental health policy focused on the protection of the public from people with mental health problems by segregation ○ Hints of inclusion began emerging in the 1960s with the civil rights movement and advances in psychotropic medications	○ Treatment for addiction problems informed and organized by the AA and 12-step models; reliance on mutual help	○ **1969 The amended Criminal Code** allowed provinces to initiate provincial lotteries; the debt of the 1967 World's Fair and 1976 Olympic Games in Montreal contributed to momentum for the legalization of gambling in Canada
The 1980s	○ **1982 Psychiatric Patients Advocate Office** – "rights advisors" started to provide consultation services for clients ○ **1983 Towards the Blueprint of Change (the Heseltine report):** advocated for less restrictive services placed in community-based service providers ○ **1988 Building Community support For People: A Plan for Mental Health in Ontario (the Graham Report):** shifting the paradigm towards community mental health care; identification of individuals with MH and	○ **1987 Development of the National Drug Strategy** as a response to the "war on drugs" in the US with an emphasis on supply reduction ○ **1988 The Federal Government created the Canadian Centre on Substance Abuse [CCSA]-** the national body for coordination of national priorities in drug policy	○ **1983 The Canadian Foundation on Compulsive Gambling** (Ontario) was founded to advocate for health services for compulsive gamblers; it later transformed into **The Responsible Gambling Council** that focuses on prevention of problem gambling ○ **1985 Amendment to the Criminal Code:** province is given exclusive control over gambling; electronic machines for gambling lead to the wider spread of gambling activities

Time Period	Mental health policy	Addictions policy	Gambling policy
	alcohol/substance use/abuse fall between cracks of MH and alcohol and drug treatment programs; it called for co-ordination and collaboration in assessment and treatment.		
The 1990s	○ **1995-1998 Health Services Restructuring Commission** appointed by the Ontario Ministry of Health to restructure and rationalize the health care system in Ontario; results in closures and mergers of health services including mental health and addiction services as a result of the commission's mandate ○ **1998 CAMH:** Amalgamation of two mental health and two addiction service providers; integrated treatment for concurrent disorders becomes one of the Centre's priorities	○ **1996 Travelling the Same Road: A Report on Concurrent Disorders in Ontario; ARF** - A report based on the provincial survey on concurrent disorders, acknowledges the problem and identifies the unmet needs among the clientele	○ **1993** all provinces start to fund treatment services for problem gambling treatment ○ **1996 The Ontario Problem Gambling Strategy** approved by the MoHLTC, guiding the funding for prevention, treatment, and training for professionals in the province

Time Period	Mental health policy	Addictions policy	Gambling policy
		○ **1997 Concurrent Disorders Policy Consultation Document** developed by the Concurrent Disorders Task Force of the Public Policy Committee CMHA, Ontario Division: concludes that there is lack of information and understanding about concurrent disorders	
	○ **1999 "Making It Happen": Implementation Plan for Mental Health Reform** (Ministry of Health Ontario) Follow-up of the Newman report; decentralization and integration with the broader continuum of care provided by health and social services deemed important	○ **1999 "Setting the Course": A Framework for Integrating Addiction** developed by OSAB – with the focus on integration and rationalization of services – one of the main topics was the inclusion of problem gambling treatment into addiction treatment services; specialized services for problem gambling became funded by two percent of gross slot machines revenues	

Time Period	Mental health policy	Addictions policy	Gambling policy
The 2000-	○ **Appointment of Regional Task Forces (9 regions)** by the MoHLTC to provide directions for the implementation of the principles in the provincial MH policy, "Making it Happen" and to develop recommendations for regional improvements to mental health services as part of MH reform in Ontario	○ **2001 Best Practices. Concurrent Mental Health and Substance use Disorders (Health Canada, developed by Rush and associates)**: the catalyst for concurrent disorders "awareness" in clinical practice, brings an extensive overview of the literature on treatment of different subpopulations; program and system integration was clearly defined for the first time; feedback from clinicians and service users is used to support the argument that integrated treatment is needed for the subpopulation with concurrent disorders;	
		○ **2002 The Canadian Executive Council on Addictions (CECA)**–an initiative of four leading addiction service providers in Canada (including CAMH). The founding members of the Council with national and provincial mandates became part of high-level policy making process in addiction policy – in 2008 they commissioned B. Rush to write a report on integration of concurrent disorders	○ **2000 The Ontario Problem Gambling Research Center** was created by MoHLTC as an arms-length funding agency for the research of problem gambling

Time Period	Mental health policy	Addictions policy	Gambling policy
		○ **2003 The National Drug Strategy,** focused on comprehensive treatment including harm reduction ○ **2005 The National Framework for Action to Reduce Harms Associated with Alcohol and Other Drugs and Substances;** after the change in Federal government leadership in 2004, the national organizations from various sectors developed the document ○ **2007 The National Anti-Drug Strategy;** Developed by the Conservative government; harm reduction is not a part of the strategy ○ **2008 The National Treatment Strategy,** the National Treatment Strategy Working Group is launched as an initiative of the CECA and the Canadian Centre on Substance Abuse (CCSA); the group consists of 30 leading experts in addictions in the country and develops the national treatment strategy for addictions and the "tiered model" of treatment system developed. In the case of concurrent disorders a "no wrong door" policy for the	

Time Period	Mental health policy	Addictions policy	Gambling policy
		assessment of concurrent disorders is recommended ○ **2008 The report on integration of mental health and addiction services and systems** lead by Rush and associates, which challenges the integration movement. There are new findings on prevalence data, "the rule rather than exception" metaphor is true only for addictions, but for mental health, concurrent disorders are the exception rather than rule; the need to look at different subpopulations is identified.	

- **2006 The Local Health System Integration Act**

- **April 2007** Establishment of Local Health Integration Networks that plan, fund and coordinate health services locally; 12 out of 14 newly established LHINs recognized the integration of mental health and addiction as one of their priorities

- **2009 "Every Door is the Right Door",** a mental health and addiction policy document developed by MoHLTC which emphasizes an integrative approach to service delivery. It was released to the public for feedback in July 2009

5.2 The Institutional Environment of Mental Health and Addiction Sectors in Ontario

Operating in such an unstable national and provincial context, mental health and addiction services in Ontario have been experiencing a surge of various integration-related activities resulting in structural changes, collaborations, coalitions, and cross-training of professionals. These were accompanied by recommendations and best practice models that elaborate on the idea of integrating systems, services, and programs. The integration of mental health and addiction services has often been viewed as a panacea for most, if not all, the problems related to the complex needs of populations with concurrent disorders.

Integrating both systems and services in Ontario has gained intensity over the last fifteen years and the integration "movement" has become highly institutionalized (Health Canada, 2001; Rush, Fogg, Nadeau, & Furlong, 2008). I will lend my support to this argument by describing the changes in public perceptions of mental health and substance use, how these changes have been reflected in the policies on integrated treatment of concurrent disorders, and how they trickle further down to ideologies of care. I will also analyze policy reports and documents that illustrate how the rationale for integration has been developed and adopted by the various social actors in both systems.

5.3 Shifting the Paradigm: Building Community Mental Health Services in Ontario

The civil rights movement that started in the 1960s has been instrumental in setting the stage for major changes in the perception of mental health, mental illness, and addictions among the general Canadian public. It has also been considered one of the factors that initiated the process of deinstitutionalization in Ontario (Hartford et al., 2003; Kirby, 2004a). Scull (1984) suggests that deinstitutionalization was a result of various factors, including the movement for greater individual liberties, an emergence of psychoactive medication as well as a focus on cost containment, and changes in public funding. Indeed, the process of deinstitutionalization in Ontario was preceded by the changes in legislation for involuntary hospitalization (Ontario's Mental Health Act, 1967) that identified the "patient's own safety or the safety of others, rather than the patient's welfare, as the basis for compulsory psychiatric examination or committal" (Hartford, et al., 2003, p. 67 quoting Sharpe, 1979).

Scheid (2004) notes that the most remarkable change in the perception of mental health and mental illness by professionals and the general public was the shift from custodial to rehabilitative care. Individual beliefs and opinions that were part of the treatment ideologies were then re-affirmed or transformed through training and work experiences and were then reproduced as professional norms influenced by the wider organizational context. The ambiguity of

technologies used in mental health and substance abuse treatment services makes treatment ideologies the more influential catalyst[6] (D'Aunno & Price, 1985; D'Aunno, Sutton, & Price, 1991; Hasenfeld, 1985).

The introduction of the Canada Health Act in 1972 eliminated the direct involvement of private insurance companies in the coverage of psychiatric care and led to the expansion of available psychiatric care in general hospitals and community mental health and addiction programs across the country (Hector, 2001). The subsequent trend towards smaller community-based treatment centers and psychiatric units in general hospitals became yet another part of the deinstitutionalization of psychiatric care in Canada; it was endorsed by the Canadian Mental Health Association (More for the Mind, 1963). Some psychiatrists at this time acknowledged that large institutions can not provide effective care and advocated for the creation of smaller psychiatric units within communities or general hospitals (Simmons, 1990). On the other hand, other institutional staff claimed that more resources were needed to increase the quality of institutional care at the hospital or large psychiatric service level (Greenland, et al., 2001).

The rapid decrease of available psychiatric beds in Provincial Psychiatric Hospitals [PPHs] from 15,257 in 1965 to 4,948 by 1980 reflects changes that have been part of the cost containment movement (Rosenthal, 1998) as well as

[6] "The technology of an organization includes all the methods for achieving the product-oriented goals....it includes the tools used in the achievement of the ends as well as certain systems of thought...including a diagnostic system and an evaluation system" (Eaton, 2001, p. 264).

the introduction of neuroleptic drugs (Hartford et al., 2003, p. 67)[7]. However, the closure of PPHs and the decrease in hospital beds have been perceived more as ad hoc activities rather than as part of a planned mental health reform. Provincial governments, either at the behest of various social actors (the general public, professionals, service users) or by pursuing their own agendas, have periodically closed hospitals throughout the past two decades (Hector, 2001; Kirby, 2004a).

The most recent decrease in psychiatric beds in Ontario was implemented as part of the restructuring of health care as part of the conservative agenda in the late 1990s (HSRC, 2000). The number of psychiatric beds dropped to 35 beds per 100,000 people when the recommendations of the Health Services Restructuring Commission (HSRC) were adopted by the Ministry of Health (Hector, 2001). Public concern over mental health services has been exacerbated by the fact that, although 78 percent of psychiatric beds were removed during these cycles of deinstitutionalization, those resources were not redistributed into community treatment. The models and attitudes of service providers were thus considered inadequate according to service users and observers (Pomeroy, Trainor, & Pape, 2002).

The changes in institutional environments of mental health services during the past twenty years, including the effects of deinstitutionalization, have decreased the reliance that individuals' with mental health problems have on formally trained professionals and rather increased their utilization of non-medical professionals and self-help groups (Pomeroy, Trainor, & Pape, 2002).

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[7] There was an attempt to offset the rapidly declining number of psychiatric beds in PPHs by the new psychiatric beds in general hospitals. Still, in the 1980s Ontario had 81 beds per 100,000 people.

The shift from institutional care to community health care with a greater emphasis upon peer support, however, threatens the status of formal treatment providers. The ongoing re-medicalization of mental health and substance use problems based on the recent proliferation of the neurobiological model has been one response to this threat, followed by an increase in the development of new pharmaceuticals (Mechanic, 1999).

Certain components of treatment of substance use problems, such as harm reduction models provided through methadone and buprenorphine maintenance in addition to medically assisted withdrawal became increasingly informed by developments in pharmaceutical research (Ray & Ksir, 2004). Addiction problems and related issues such as problem gambling have shifted towards using a biopsychosocial perspective which also emphasizes underlying psycho-social factors (Beauchesne, 1997). Since the 1990s, the initial reliance on volunteerism and peer support in the addiction field in Ontario has been replaced by more professionalized addiction treatment. However, self-help groups still play an important role in the recovery process (Ontario Substance Abuse Bureau, 1999).

The main planning documents and reports in the mental health and addiction sectors demonstrate how certain concepts, ideas, or innovations, such as integration, have become institutionalized. This has occurred, for example, through the evolution of organizational language (Meyer & Rowan, 1977/1991) and the production and dissemination of texts (Phillips, et al., 2004)[8]. There is a

[8] The authors refer to written documents, verbal reports, artwork, spoken words, pictures, symbols, buildings and other artifacts as well as "any kind of symbolic expression requiring a

noticeable absence in the recognition of concurrent disorders in policy reports in Ontario prior to the 1990s. For example, the recommendations of the Heseltine Report (1983) focused on advocating for less restrictive community-based services, for individuals with mental health issues only, that would resemble clients' home environment (Hartford, et al., 2003). However, the major problem in this period was that such homelike services were very scarce and almost non-existent.

Consequently, individuals with mental heath problems became highly 'visible' as they were practically moved from psychiatric wards to street benches (Hartford, et al., 2003). The lack of community-based mental health services, particularly housing and other support systems, a result of slow allocation of funds and compartmentalization of services, became part of the heated public debate. According to Heseltine (1983), the number of articles in Toronto's two major newspapers between 1979 and 1981 focusing on mental health issues tripled. Moreover, the highly publicized deaths of two patients in PPHs led to establishing the Psychiatric Patient Advocate Office in 1982 to provide patients with access to a "rights adviser" in cases of involuntary admission or treatment (Hartford et al., 2003). The institutionalization of a "rights culture" allowed for changes in the organizational structures of mental health services and helped underscore the need for reform.

Hartford, et al. (2003) identifies the report of the City of Toronto & The Supportive Housing Coalition (1982) on insufficient community-based services

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physical medium and permitting of permanent storage" (Taylor & Van Every, 1993 quoted in Phillips et al., 2004, p. 636).

along with the critical report on mental health systems released by the Auditor General in Ontario (1987) as the main catalysts for change. The end of 42 years of Conservative government was an impetus for promoting the consideration of change in the mental health sector in the 1980s. Following these vital events, the report *Building Community Support for People: A Plan for Mental Health Services in Ontario"* (commonly referred to as the Graham Report) developed by the Provincial Community Mental Health Committee of the Ontario Ministry of Health, was the turning point for mental healthcare in Ontario (Hartford et al., 2003; Wasylenki, 2001). The Graham Report supported the ongoing deinstitutionalization of the mental healthcare system including the delegation of administrative and fiscal responsibilities to regional authorities. The main emphasis was placed on the need to address the problems of people suffering from severe mental illness and on the changes in perceptions of these clients as a result of new language and terminology (consumers and partnership) based upon the earlier work of the Canadian Mental Health Association (Wasylenki, 2001). The recommendations of this Report were, however, not implemented in that same decade.

With regard to comorbidity, the Graham Report (1988) identified people with a "dual diagnosis" (the co-occurrence of mental health problems and developmental disability or mental health problems and a physical impairment) as those who are often overlooked or undermanaged in the mental health treatment system.

Part of this problem was based on the terminology used to identify those with multiple problems since it did not differentiate between different subpopulations; specifically, individuals with mental health and substance use problems were not recognized as a specific group[9]. Therefore, this report's text on the problem of dual diagnosis did not recommend integration with the main addiction treatment system in Ontario as it was still considered a separate entity.

The Graham Report has been praised for outlining the philosophy and principles of the community-based mental health system, putting clients at the center of the reform, and its attempt to build new partnerships within the mental health community. Although the report did not acknowledge co-occurring mental health and substance use disorders in particular, recognition of other co-morbidities could have instilled the perspectives needed to recognize concurrent disorders in future.

Phillips, et al. (2004) point out that institutionalized environments tend to be influenced by changing discourse in the field. This is consistent with the ten-year implementation strategy *"Putting People First: The Reform of Mental Health Services in Ontario"* (1993) that was based upon the recommendations of the Graham Report but did not specifically outline plans for the integration of mental health and substance use services. It did, however, emphasize the need to integrate community mental health services with *other* services such as case

[9] It was not until 1996 that the Addiction Research Foundation referred to co-occurrence of mental health and substance use problems: "concurrent or comorbid disorders would better differentiate between those individuals suffering from both psychiatric and substance abuse problems from other 'dual diagnosis' groups" (Melinyshyn, Christie, & Shirley, 1996, p. 3). In 1997, the Concurrent Disorders Task Force of the Public Policy Committee of Canadian Mental Health Association Ontario Division was established and clearly stated that the term "concurrent disorders" represents a combination of mental health and substance use problems.

management, housing, and service users' support. Under this policy framework, people with concurrent disorders were identified as members of an under-served population along with women, aboriginal peoples, youth, and other vulnerable groups (Ministry of Health, 1993).

The Ontario Addiction Sector in the 1980s

In the 1960s and 1970s, the criminalization of drugs came under scrutiny when the social distance between drug users and mainstream society narrowed. It was difficult to preserve the seriousness of criminal behavior when a substantial portion of the population engaged in recreational drug use, particularly LSD and marijuana (Erickson, 1992). Despite this trend, the liberal approach to drug use proposed by the Canadian Le Dain Commission (1969-1974) was never fully applied to drug policy. Conciliatory liberal sentiment towards drug policy had diminished by the 1980s.

In the 1980s, new circumstances returned the spotlight to the population with substance use problems. As the Graham report became a catalyst for change by outlining the main principles to reform mental health services in Ontario, the substance use sector was affected by the launch of the first National Drug Strategy in Canada in 1987. The development of the National Drug Strategy was in direct response to the attitudes towards illicit drugs in the United States. In 1986, just two days after President Reagan had declared the "War on Drugs", Canadian Prime Minister Brian Mulroney deviated from a prepared speech to announce that, "drug abuse has become an epidemic that undermines

our economic as well as our social fabric" (Erickson, 1992, p. 248). Erickson quotes an official from Health Canada privately reflecting on the speech: "when he [the Prime Minister] made the statement then *we* had to make it a *problem*" (quoted in Erickson, 1992, p. 248, italics in original).

Indeed, the institutional environment of substance use services started to change in response to these approaches to illicit drugs by North American society. These perceptions were strongly associated with the social characteristics stereotypical of those who engage in drug using behaviour (Cohen, 1990; Courtwright, 1982; Csiernik, 2003; Erickson, 1992; 1998; Harding, 1988; Kandall, 1996; Musto, 1987; Peele, 1985; Zsazs, 1974; 2003). As outlined above, large scale experimentation with drugs in the 1960s and 1970s by white middle-class youth, and the expansion of problem gambling in the 1980s and 1990s forced the development and delivery of treatment interventions with the support of professionals and the general public in the late 1990s and early twenty-first century (Acker, 2002; Bernhard & Preston, 2004; Castellani, 2000; Cosgrave & Klassen, 2001; Erickson, 1992).

In contrast, the use of crack cocaine in the 1980s by primarily urban non-white populations generated harsher policy measures that were designed to tackle the "crack epidemic". Society was terrified by the "crack baby" phenomenon, a fear that was fuelled by numerous research studies, and by the US media's exagetation of the effects on children born to crack-addicted mothers (Ray & Ksir, 2004).

Reagan's declaration of a new "Drug War" in 1986 inspired a new era of "prohibitionism" in Canada. By the 1980s, crack cocaine that had begun to make its appearance in American cities, "was portrayed as the drug that finally fulfilled all the expectations of the "demon drug mythology" (Erickson, 1992, p. 254). Highly sensationalized and negative accounts of crack use created a "drug scare" which justified increasingly repressive measures against drug users. Erickson (1992) saw the differences in illicit drug use between the United States and Canada as an assumption of "cultural lag" (p. 243). Cultural lag presupposes that differences in illicit drug use in the two countries is simply one of use and that it was only a matter of time before Canada must contend with the same level of problem activities as the United States. Assumptions about the similarities between American and Canadian patterns of drug use will be addressed in a later section of this chapter.

To reiterate, the social response towards certain psychoactive substances does not reflect only the pharmacological effects of drugs but also the social position of drug users and the specific circumstances of drug use. Cohen, McCubbin, Collin, and Perodeau (2001) report that the "growth in the consumption of prescribed stimulants has coincided with an escalation of the 'War on Drugs' which especially publicizes the dangers of illicitly used stimulants" (Cohen et al., 2001, p. 452). On the one hand, pharmacological research and the pharmacological "industry" have become an integrated part of treatment interventions for people with problems related to illicit substance use. On the other hand, self-medication and "off-label" use of prescribed psychoactive

substances have become a behavior itself that requires treatment. From the economic perspective, the profit for pharmaceutical companies is one of the powerful structural forces that influence mental health and addiction practice in a capitalist system such as the United States (Bentley & Taylor, 2002).

The federal initiative that followed the rhetoric of the "War on Drugs" – in the form of newly adopted National Drug Strategy (1987) in Canada - was designed to provide direction and support to reducing both the supply and demand of illicit drugs. Another step taken to address the drug problem in Canada was the creation in 1988 of a non-governmental organization - the Canadian Centre on Substance Abuse [CCSA] - with a legislated mandate to "provide national leadership and evidence-informed analysis and advice to mobilize collaborative efforts to reduce alcohol- and other drug-related harms" (CCSA, 2009). Although CCSA has initiated and coordinated several national policy initiatives, its authority has been limited because, as one of my research participants explained: *"It does not have money to give us, so it does not have any mandate"* (P7).

The drug strategy in Canada was developed much earlier than the national strategy for the mental health sector, where a draft proposal has only recently been presented to the public (Mental Health Commission of Canada, 2009). Nevertheless, Erickson (1992) and Fischer (1997) report that despite the dramatic turn in the government's rhetoric regarding substance use in the late 1980s, there was no significant shift of the federal initiatives regarding illicit drugs. Ten years after launching the National Drug Strategy, the stigma attached

to substance use and treatment services still remained and the funding of addiction services had not improved. In fact, the decrease in funding was so significant that service providers and activists characterized 1997-1998 as the 'sunset' of the Canada Drug Strategy (Collin, 2006). Typically, the minimal support for addiction services in Canada and in Ontario has been paralleled by the reigning ideology of Conservative governments notorious for their punitive approach to substance use (Hathaway & Erickson, 2003).

As for gambling, it has spread gradually in Canada over the past thirty years. The major impetus for the opening of the most recent gambling venues, however, was the major amendment to the Criminal Code in 1985 that permitted the use of electronic machines and granted provinces the exclusive control over gambling accessibility (Canada West Foundation, October 1999; Korn, 2000). This shift in government policy was based on a desire to generate additional revenue without unpopular tax increases (Korn, 2000). Consequently, rapidly expanding gambling in North America, Western Europe, and Australia was redefined as an acceptable leisure activity in an era of new social and economic morality (Cosgrave & Klassen, 2001). Legal gambling was introduced in Canada in the 1960s when the Province of Québec and the City of Montréal lobbied for the introduction of provincial lotteries to help alleviate the financial burden of 1967 World's Fair and the 1976 Olympics (Canada West Foundation, October 1999). Under the amended Criminal Code (1985) legal gambling activities in Canada can only be conducted with the involvement of the provincial governments, whether through licensing, regulating, or direct operation. An

increased promotion and perception of gambling as a leisure activity allowed the provincial governments in Canada to establish and manage Video Lottery Terminals (VLTs) and slot machines in addition to ticket lotteries, bingo halls, raffles, horse racing, and other gambling events at various fairs and exhibitions throughout the province (Canada West Foundation, October 1999). And yet, the awareness of gambling as a problem is evident from the initiative taken by a former problem gambler to establish an independent organization to promote treatment services for problem gamblers - *The Canadian Foundation on Compulsive Gambling* (1983) (Ontario) - that was later transformed into *The Responsible Gambling Council* focusing on prevention and on increasing the public awareness.

A document review reveals that concurrent disorders were not acknowledged extensively in the main mental health and addiction policy reports of the 1980s. The changing institutional environment of mental heath and addictions in Canada and Ontario, however, has altered the way mental health and substance use problems are perceived by professionals and the public. Greater recognition of the needs of this population is reflected in clinical research that, according to Kirby (2004a), became diversified and specialized in the late 1980s. Certain subgroups, including women and members of First Nations, did not respond well to general treatment (Kirby, 2004a), and individuals with concurrent disorders were identified as an at-risk groups easily excluded from services for being unfit for general treatment services (Health Canada, 2001).

5.4 From a Fragmented Service System to Clear Responsibilities and Accountabilities

In this section, I will provide information on the structural development of the institutional fields of mental health and addiction services in Ontario during the 1990s. This time period is particularly relevant to my two cases since they have both been shaped by one of the mergers resulting from a direct government mandate during the restructuring of health care systems in Ontario.

Restructuring Mental Health Services in Ontario

As in the case of the National Drug Strategy (1987), where the outlined plan for action became more political rhetoric than action (Erickson, 1992; Fischer, 1997), the later reviews of the systemic changes in the Ontario mental health sector were not plausible. By the midpoint (1998) of the process of implementing the recommendations of *Putting People First: The Reform of Mental Health Services in Ontario (1993)*[10], the Ontario Conservative government re-evaluated the strategy launched by the New Democrats to identify areas for improvement. The five-week consultation review of the mental health system by D. Newman, M.P.P. and Parliamentary Assistant to the Ministry of Health, claimed that little had changed: "the former government failed to provide the necessary dollars and failed to implement the reform necessary to develop a strong mental health system" (Newman, 1998). In a broader context, this

[10] It was the first document that specified the shifts in funding towards community mental health care (60%) and institutional care (40%) from the previous 20/80 split (community care vs. institutional care) (Hartford et al., 2003).

statement blames the fiscal restraint caused by the recession at the beginning of the 1990s for the inaction condemned by Newman. Rosenthal (1998), however, asserts that in western democracies, even social democratic parties have succumbed to using the myth of a "never-ending crisis" as an excuse to retreat from public health care funding and to accept the logic of a capitalist system that claims that the "improvement in human health must wait until good times return" (p. 25).

Except for the attempts to restructure and rationalize the mental health system already taking place through the work of the *Health Services Restructuring Commission* (HSRC or the Commission)[11], Newman's review is a response to a "few highly publicized incidents of violence involving previously hospitalized patients" (Hartford et al., 2003, p. 70). His recommendations led to the legislative changes in the Mental Health Act (2000) with respect to community treatment orders for people with severe mental disorders. The resulting report, *2000 and Beyond: Strengthening Ontario's Mental Health System* (1998), was followed by the implementation plan and operational framework, *Making It Happen* (Ministry of Health, 1999a, 1999b), a document that called for the reduction of fragmented services with shared care agreements, common assessment, treatment protocols, mergers, and collaborations among various providers.

[11] The Commission consisted of a group of volunteers appointed by the Government chaired by Duncan Sinclair, a former Dean of Medicine at Queen's University (Kingston). The other 12 members were medical professionals, academics and former hospital board members (HSRC, 1999).

Prior to Newman's review, the Ontario Conservative government had begun an initiative that significantly shaped the health care system in the province, including mental health and addiction services. The newly-established Health Services Restructuring Commission (March, 1996) was designed to help "expedite hospital restructuring in the province, and to advise the Minister of Health[12] on revamping other aspects of Ontario's health system" (HSRC, 2000, p. 1)[13]. The aim of this commission was to rationalize the hospital system, increase the quality of care, and deal with "fiscal realities of the late 1990s and early 21st century" (HSRC, 2000). The mental health system was identified as lacking a clear vision and in dire need of reform. The money saved from increased efficiency in health care would be returned to the Ministry's budget and later reinvested to build a strong community mental health system.

Ontario, as one of the last provinces to approach health care reform, established this province-wide "arms-length commission with a limited term to determine what changes with respect to hospitals were in the public interest and [to] direct that they be made" (HSRC, 2000, p. 4). In this instance, status and power of the Commission show how adamant the Ontario Government was about the health care reform. DiMaggio and Powell (1983/1991) believe that government policies and assigned mandates serve as a direct impetus for organizations to comply with their environment. The Commission became one of

[12] At the time of the HSRC establishment, the Ministry of Health and Long-Term Care was known as the Ministry of Health. After the elections in 1999, the Ministry of Health was renamed the Ministry of Health and Long-Term Care (MoHLTC).

[13] The Commission's four year mandate was to make decisions about restructuring Ontario's public hospitals, serve as an advisory body to the Minister of Health and to recommend how to improve the health care system's efficiency and quality of care.

the central players in the institutional environment with the "right to speak" and disseminate its recommendations – through reports and media communication - to a larger audience of social actors. This concurs with the notions of Philips et al. (2004) on the importance of the central position of a social actor that becomes a moving force for disseminating newly institutionalized practices. According to DiMaggio and Powell (1983) formal pressures placed on organizations "may be felt as force, as persuasion or as invitation to join in collusions" (p. 150). The Commission made it clear that the reform would be diverse in its implications as "some hospitals will have merged, some will have entered service and management alliances, some will have closed" (HSRC, 2000), thus alleviating fears of enforced change.

One of the study participants who witnessed the changes in the mental healthcare system introduced by the Commission said that "these were just business people and they applied business principles to it" (Field notes, November 18, 2008). This statement demonstrates the belief that governments use their reigning ideologies to force public services to emphasize the principles of their own political agenda and form institutional environments that pressure organizations to adapt (Scheid, 2004). Although some hospitals that attempted to resist the pressure to restructure, and opposed the Commission's recommendations through legal action, in all cases but one the court ruled in favour of the Commission (HSRC, 2000).

The model of restructuration, rationalization, better coordination, and integration of services has been embraced by governments as a "template" for

the successful delivery of services in almost every component of the health care system. However, the Commission expressed its disappointment in the lack of political will on the side of the Ministry of Health to act on some of its proposed recommendations (HSRC, 2000). Among the immediate outcomes of hospital restructuring was the significant consolidation of governance and senior management which would provide opportunities to save and reassign resources to patient care through administrative efficiencies (HSRC, 2000). The Commission was very clear about its understanding of health care reform: "the first requirement of any 'system' (a coordinated enterprise) is that the several parts of which it is made have to march to the beat of a single drum" (HSRC, 2000, p. 32). Centralization and homogeneity of governing structures thus clearly became a means for better control of the reformed health system and consequently resulted in bigger savings. This was also acknowledged by one of the interviewed participants in my study:

> *So, I think that there is the Ministry of Health – slash – the Government – slash – political party "let's save money" concept ...there is this mental concept that there is a mental health system that exists over here. There is a whole infrastructure that has to be paid for that supports each of these and they are not that far apart and so if we had one infrastructure that supported them then we could save a lot of ...a lot of money. So, I think that's one of the things that makes the idea (integration) popular (P11).*

One of the direct results of the restructuration process was the HSRC's recommendation that the Clarke Institute of Psychiatry, the Addiction Research Foundation, the Donwood Institute, and the Queen Street Mental Health Center, with help from the assigned HSRC facilitator and the assistance of the University

of Toronto, merge into one organization with a provincial mandate on education, research, and policy (HSRC, 1997). I will analyze the organizational structure of the newly established centre in Chapter 6.

Rationalization of Substance Use Services in Ontario

During the 1990s, addiction services in Ontario were subject to restructuration, rationalization, and amalgamation with other services, as well as integration into community mental health or social services. The availability of new synthetic drugs as well as the proliferation of gambling as a popular pastime for Canadians brought additional challenges to be addressed by the addiction sector (Kirby, 2004a).

When the Provincial Advisory Committee on Drug Treatment issued *Treating Alcohol and Drug Problems in Ontario: A Vision for the 90s* (Provincial Advisory Committee on Drug Treatment, Ministry of Health, 1990), recommending that more cost-effective outpatient services be provided in multifunctional treatment agencies, a signal was delivered that addiction services in Ontario were struggling to maintain their legitimacy. The turbulent institutional environment of the addictions sector was marked by an economic slowdown and the need to show greater efficiency in provided services. This was in conjunction with the desire to rationalize addiction services in the United States (Durkin, 2002; Wells, Harris-Lemak, & D'Aunno, 2005). The greater attention paid to efficacy and effectiveness of addiction services, including the growing influence of managed care in the 1990s, was related to new inter-organizational

partnerships, and amalgamation or closure of public or private services (Wells, et al., 2005). By merging with hospitals or mental health centers, substance use services increased their survival chances by avoiding the lack of resources that small services usually contend with (D'Aunno, Sutton, & Price, 1991; Wells et al., 2005).

The rationalization movement was supported by a desire to enhance "traditional" addiction services and address clients' psychosocial and medical needs in one place, ideas that already resonated in published clinical research (Durkin, 2002). This research showed that more successful treatment outcomes were directly related to the receipt of supplemental services; clients were found to be more likely to participate or remain in treatment if most or all of their needs are met at once (Durkin, 2002; Volpicelli, Markman, Monterosso, Filing, & O'Brien, 1999). Clinical studies also indicated that individuals with severe substance use problems found it difficult to progress through treatment when their complex needs were not met (McLellan, Hagan, Levine, Gould, Meyers, Bencivengo, et al., 1998; Durkin, 2002).

The American approach to a "War on Drugs" in the mid 1980s that resonated in Canadian drug policy as well likely led Canadian policy planners, researchers, and clinicians to become part of a mimetic isomorphic change based on the American rationalization movement. In Ontario, the rationalization of addiction services was enacted when the Ministry of Health began reforming the system. The planning and funding of addiction treatment was placed under a

single governing body: the Ontario Substance Abuse Bureau [OSAB][14]. Although establishing the OSAB was alleged to be part of the systemization and improved governance of compartmentalized provincial drug services, one of my research participants described the planning process of the Ontario drug policy as a reactive political measure provoked by public discontent with the status of addiction services in the province:

> *The things that I have observed being the true political drives that result in actual funding and policy change is far more personal that it is policy. An example being that the Ontario Substance Abuse Bureau was based upon the young boy Benji dying in the Toronto Harbor and huge political furor that focused on the fact that this young person had died. It was a political game to be played and as a result of that it evolved into the Substance Abuse Bureau actually being funded and recognized and supported, which was a step of improvement but it had more to do with dealing with adverse publicity than it had to do with true motivation to be of assistance (P11).*

The aim of the Interministerial Committee on Substance Abuse[15] (1992) was to involve other sectors in tackling the drug problem. The committee's mandate was to create a 10-year vision and set goals for the new provincial drug strategy delivered in the report *Partners in Action: Ontario Substance Abuse Strategy* (Health Canada, 1993). A part of this reform - the Rationalization Project (1996) - developed a centralized information system to support the planning and evaluation of specialized substance use services. This approach, brought forward by the researchers of the former Addiction Research Foundation, became part of

[14] OSAB became part of the Ministry of Health and later the MOHLTC Community and Health Promotion Branch.

[15] The Committee was established in May 1992 and comprised of senior representatives from 15 ministries and 3 directorates/secretariats (Ministry of Health, 1993, background document).

the provincial reform initiative (Ministry of Health 1993; Ogborne, Braun, & Rush, 1998; Rush & Ekhdal, 1990). The OSAB funded the development of such projects as the Drug and Alcohol Registry of Treatment [DART] (1991) - a centralized registry of treatment information on the availability of substance use services in the province - as well as the development of the Drug and Alcohol Information System [DATIS] (1994) which focused on recording clients' demographics, service utilization, and information on total costs of treatment services (Office of the Provincial Auditor, 1999; Ogborne, Braun, & Rush, 1998). However, DATIS was met with different levels of cooperation by addiction agencies during the project's developmental phase (Ogborne, et al., 1998).

Addiction services' main concern was that this information system could be used to condemn them if they appeared to be ineffectual, despite the fact that effectiveness is a qualitative measurement. Their concern was not unfounded; indeed, the standardized performance indicators and evaluations are considered insensitive to human service organizations, particularly when clients with chronic or severe conditions need client-centered care rather than care based on standards of technical efficiency (D'Aunno & Vaughn, 1995; Scheid, 2004; Schlessinger & Gray, 1999). The conflict between client-centered care and technical efficiency is even more visible in mental health and addiction services than in other sectors as they tend to be less technically driven (Schlesinger & Gray, 1999). Moreover, the clinical autonomy of professionals working in both fields is challenged by technical criteria and standardization and

decreases the legitimacy of professional norms and values in the provision of mental health and addiction services (Scheid, 1990; 2004).

Following the provincial drug reform and its restructuration activities, the final report by the Provincial Auditor (1999) on the OSAB activities indicated that changes in the structure of addiction services were not implemented along the guidelines of the Provincial Drug Strategy (Ministry of Health, 1993). The audit concluded that only one multi-service agency had been created since 1990 and that the recommendations of the Rationalization Project had not yet been acted upon (Office of Provincial Auditor, 1999). Moreover, the Ministry did not have adequate mechanisms in place to ensure that cost-effective addiction treatment services were being provided in the province.

The purpose of forming multi-service addiction treatment centres or inter-organizational networks of care was to create an integrated system combining fragmentary treatment services (Ministry of Health, 1993; Kirby, 2004a). Although the need for the standardization of services was commonly supported by several government initiatives (Health Canada, 1993; HSRC, 1997; OSAB, November 1993; OSAB, 1999), the Ministry itself was criticized for failing to provide criteria or a timeline to achieve the goals outlined in the Provincial Drug Strategy (1993) (Office of the Provincial Auditor, 1999). In the same year, the OSAB released *Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario* (OSAB, 1999), another planning document for more effective coordination of addiction services in the province. It is, however, hard to ascertain whether this document was produced in response to the audit. The

framework served, according to one of my research participants, as a blueprint for service providers attempting to consolidate the addiction sector more quickly than the mental health sector:

> *There was a...it is called the Setting the Course [report]. That was an initiative of that time by, it was called the Ontario Substance Abuse Bureau - that was a provincial initiative. So, it was kind of a marching paper for service providers and the District Health Councils to do some strategic planning for addictions and the Ministry of Health had overseen that. We had implementation committees all across the province that were trying to move things along in a strategic kind of fashion and I think a lot happened out of that. We have...in some ways in the addictions, there is more together than in the mental health sector because they (addictions) have admission and discharge criteria, they have definitions of service and it's provincial and it was mandated by the province. You won't find that in the mental health sector nearly as much. It's been really a consistent provincial focus on that* (P7).

Setting the Course emphasized that the restructuration and rationalization process for addiction services had to be smooth and had to respect the varied organizational cultures of each organization as they merged in order to preserve the original donors, who may have trouble relating to the new larger institutions (OSAB, 1999, p. 21). Peyrot (1991) reports that, in order to survive in environments with multiple or conflicting demands, substance use services often employ a variant of symbolic adaptation called the *chameleon strategy* to attract clients and donors that desire more comprehensive services. Even if it means embracing goals that are not directly related to their treatment philosophies, organizations will do so in order to increase their chances for survival. The attempt to increase the multi-functionality of addiction services meant introducing

services with multiple, often incompatible goals to help gain a higher status for addiction treatment in the eyes of funders and the general public.

Organizational responses to different institutional demands vary according to the mechanisms being used as part of the process of institutional isomorphism (DiMaggio & Powell, 1983/1991). Coercive mechanisms of isomorphic change in the form of direct government involvement, as in the case of the sweeping mandate of HSRC to restructure or close services, force organizations to accept changes without appropriate preparation. D'Aunno, Succi and Alexander (2000) state that government policies can promote divergent organizational change by altering funding flows and by requiring organizational accountability for what resources are then allocated. Governments can also change the norms and values of these institutional environments by proclaiming, for example, that technically driven efficiency of services must be the main goal to be achieved.

Meyer and Rowan (1991) report that organizations, in order to protect themselves from an evaluation of their performance but still retain their legitimacy, decouple their formal structure from work activities in order to "maintain standardized, legitimating, formal structures while their activities vary in response to practical consideration" (p. 58). For example, when the OSAB asked addiction agencies to use "negotiating contracts" to "buy" certain services from each other to meet clients' complex needs (OSAB, 1999, p. 20), the proposal was not well received. Addiction services feared losing their independence due to more centralized authority on the part of a service provider. Thus, in order to

maintain their independence, they were prone to drafting "formal" service agreements that lacked sufficient organizational accountability (OSAB, 1999).

Proliferation of Problem Gambling Services in Ontario

The services for the treatment of problem gambling were also included in the proposed restructuration reform, even though they had to contend with their distinct evolutionary process and the status of gambling as a provincial revenue-generating activity (Canada West Foundation, October 1999). The Ministry, in its provincial framework *Setting the Course (1999),* suggested that at least one addiction treatment agency in each district should provide treatment services for problem gambling (OSAB, 1999). The audit of the OSAB, however, revealed that the Ministry did not have any mechanism in place to ensure that the $9 million, haphazardly allocated since 1996/1997 to existing addiction treatment providers, was utilized for the prevention and treatment of problem gambling as it was intended. Specifically, they had no way to measure whether or not desired results were achieved (The Office of the Provincial Auditor, 1999). Moreover, 44 addiction treatment agencies that provided problem gambling related services in the fiscal years of 1997/98 and 1998/99 had excessive funding due to a lower than projected client load. A few of my research participants confirmed that funds were provided to specialized addiction centers merely to include problem gambling treatment as an on-site option:

> *The Ministry was funding a lot of programs at that point...the Helpline, they funded a large number of programs across the province...basically giving money to substance abuse programs to add gambling as a treatment component (*P1).

All the provinces saw a dramatic growth in the number of casinos built in the 1990s and attention was duly focused upon providing state-funded treatment responses for problem gambling (Cosgrave & Klassen, 2001; Hargreave & Csiernik, 2003; Korn, 2000; McMillen, 1996; Walker, 1996). The study of Room, Turner and Ialomiteanu (1999) found that, as in the case of alcohol and illicit drugs, the higher the availability of gambling venues, the higher the prevalence of problem gambling. Although prevalence studies on problem gambling do vary, the Ontario prevalence study of Single and Wiebe (2002) revealed that "approximately 80 percent of adults gambled of whom 4.8 percent experienced problems of moderate to high severity – a rate that translated into 340,000 adults province-wide" (Annual Report 2004-2005, Ontario Problem Gambling Center). Moreover, the study of Williams and Wood (2004) found that 35 percent of overall revenue originated from the 4.8 percent of gamblers with moderate to severe problems. The provincial government was now aware that recognition of the growing need for problem gambling treatment could jeopardize revenue-building gambling as a leisure activity and, by extension, public support for the continued development of gambling venues. One of my research participants observed that the government also had a moral obligation to provide services for those who experience problems due to their gambling habits:

> *It was the fact that gambling was being developed and in fact promoted by the Government, and as a revenue creating source they knew…I think they knew that they also had to provide assistance for people with gambling problems. We had a very slow start in terms of getting clients…uh…the Government was pretty cautious about doing outreach. I mean the outreach was fine but any kind of public information, any kind of television or radio campaigns were much later…(P1).*

The role of the government in the development of services for problem gambling was also emphasized by another research participant:

> *The other thing is, as I said, the government is an owner and operator and a regulator. That means that there is a political exposure that government has. That requires them to do something and I would say that for years they didn't give much direction to the industry for example around their responsible gambling mandate. But they're starting to. The other thing that's been happening is that the lawsuits are starting to hit the industry (P10).*

The measures taken by the Ontario government, particularly through the Ontario Lottery and Gaming Corporation [OLG] has prompted the advent of new initiatives to promote responsible gambling strategies (OLG, 2009), among which is the generous funding for prevention and treatment of problem gambling. It now starkly contrasts not only the monetary amount allocated to the treatment of other addictions, but also the amount other countries' governments invest in the treatment of problem gambling:

> *What helps, compared to other parts of the world, is funding. Having the resources we have is actually fairly unique. In Canada, there is more resources generally around in the provinces than when you look at the US or other parts of the world. They drool when they think about the resources we get, the money that we get. And that is a huge part of what we can do* (P10).

Since 1999, services for problem gamblers in Ontario have been financed by two percent of gross slot machine revenues in the province, a minimum of $10 million per year (Office of Provincial Auditor, 1999). The net gambling revenue generated by Ontario increased from $0.5 billion in 1992/1993 to $2 billion in 2003/2004 (Wiebe, Mun, & Kauffman, 2006).

With an increase in the demand for treatment services, problem gambling treatment has become a part of the addiction treatment paradigm. This is the result of policy measures that increasingly include services for problem gambling on their agendas (Ontario Substance Abuse Bureau, 1999). For example, the MoHLTC Mental Health and Addiction Branch prepared an operating manual for mental health services and addiction sectors where they set the criteria by which mental health and addiction services qualify for government funding (MoHLTC, December 2003). The Ministry has clearly established both mandatory and recommended conditions for receipt of funds as follows: the agencies had to prepare separate operating plans for each type of service provided, whether it was mental health, addiction or problem gambling services (MoHLTC, December 2003). This has brought the treatment for problem gambling into a more structured institutional environment and has formalized its existence within the organizational structures of addiction services.

5.5 The New Millennium in the National and Provincial Mental Health and Addiction Environment

The new millennium has been marked by various policy making activities in mental health and addictions on both federal and provincial levels.

The Legacy of the Kirby Committee

One of the most important initiatives on the national level was the examination of the Canadian mental health and addiction system by *The Standing Committee on Social Affairs, Science and Technology* lead by Senator Michael Kirby (2001 – 2006). This national review has proven critical to the greater recognition of mental health and mental illness and particularly the stigma associated with them. For the first time, such a public policy document attempted "put [ting] a human face on the issue" (Kirby, 2006, p. 1) by giving a voice to individuals suffering from mental health problems and their significant others. The first-hand experience of service users and family members filled with confusion, frustration, and anger had a profound effect on the members of the Committee. According to Senator Kirby, "it didn't take long for the Committee to unanimously agree that the issue of mental health and mental illness in Canada requires greater study" (Canadian Psychiatric Association Bulletin, June 2003). In order to facilitate the development of the first major mental health strategy in Canadian history, the Federal Government accepted the recommendations of the Kirby's final report and created the national arms-length *Mental Health Commission of*

Canada (2007) with Michael Kirby as the first chairman. Although the Senate Committee led by Kirby had acknowledged concurrent disorders as a problem that needed attention, none of the priorities of the newly founded Mental Health Commission of Canada specifically focused on concurrent disorders. The issue of concurrent disorders has since been partially addressed with a project that identified homelessness as a major and sometimes insurmountable obstacle to recovery (Mental Health Commission of Canada, n.d.).

Addictions: Always a Couple of Notches Lower

Although The Kirby Committee put mental health and mental health problems into the spotlight, it did not bring the same attention to issues related to addiction (Kirby, 2006). The Committee acknowledged that it "has not been able to devote as much time and attention to substance use issues as it intended when it began this study of 'mental health, mental illness and addiction' [and] the [final] report focuses primarily on mental health issues" (Kirby, 2006, p. 5). It is obvious from the above quote that neither substance use nor gambling received priority from the Committee. The interim reports dealt mostly with the problems of mental health and mental illness, with only a brief review of addiction services' attempts to integrate into community mental health and social services. This review of the addiction services in Canada covers less than three pages out of a total of 249 with limited supporting material.

Although the report has been praised for acknowledging individuals with concurrent disorders among other groups with complex needs (Kirby, 2004a;

2004b), the addiction system has been left behind (Kirby, 2006). One of my study participants, a member of program management at CAMH, reflecting upon the position of both systems in Canada, stated:

> *Clearly, addiction services do not receive the same level of attention as mental health issues and this has been happening for a variety of reasons: From the funding standpoint,...federal, provincial, local, stigma still has a hugely significant effect in my opinion...addiction is pretty much in the bottom of the hierarchy of perceived deservedness of treatment and mental health is probably several notches higher but not that many (P11).*

Another research participant also confirmed that:

> *Addiction alone, separated from any concurrent issue, has a very small price on the market. It is unrecognized as a cost to society and the value of treatment is under recognized. Generally, people think treatment does not work, people prefer to fund other systems and there are a lot of questions about why to invest in that (P7).*

Ongoing marginalization of addiction services, particularly the public health oriented harm reduction model and a lack of federal and provincial leadership are reflected in some of the previous policy initiatives. Although the renewal of the National Drug Strategy (2003)[16] provided increased funding to support more comprehensive addiction treatment services, after the change of the Federal Government in 2004, the National Anti-Drug Strategy (2007) focused on prevention, treatment, and law enforcement, but completely disregarded harm reduction practices.

[16] The renewed Canada Drug Strategy (2003) was launched with $245 million invested towards more integrated approach supported by fourteen collaborating federal departments following the criticism of the Auditor General (2001) regarding previous funding, lack of leadership and failed attempts to monitor and evaluate drug services by the Federal Government.

A national initiative, originating with the actions of major treatment providers, led to the establishment of the Canadian Executive Council on Addictions (CECA) to mobilize resources and lobby for better political and public support for the addictions sector. In 2002, CAMH, the Kaiser Foundation (BC), the Alberta Alcohol and Drug Abuse Commission, and the Canadian Centre on Substance Abuse represented by their senior executives, formed *The Canadian Executive Council on Addictions (CECA)*. These agencies, having national and provincial mandates, coalesced in an attempt to become a high-level policy-making process in the addictions sector in Canada (CECA, 2008). Indeed, this reflects the trend of powerful organizations to form networks, coalitions, and collaborative partnerships to gain and maintain their status and to influence their institutional environments (D'Aunno, 2006; Phillips et al., 2004). There are two dominant relationships between inter-organizational collaborative processes and institutional fields: the institutional fields serve as sources for collaborations and the collaborations serve as processes that maintain and modify institutional fields as resources for innovation, reproduction, and translation of institutional rules (Phillips, Lawrence, & Hardy, 2000). CECA has been instrumental in launching national surveys emphasizing the societal harm of alcohol and drug use. The most recent initiative of CECA that related to concurrent disorders was the commission of a CAMH researcher to prepare a paper on the integration of mental health and substance use services and systems (report of Rush et al., 2008a). CECA accepted the report's recommendation to be more cautious about using integration as a panacea for all problems in both systems. The report

stated that the "integration train has clearly left the station" (Rush et al., 2008a) as the idea of integration has been embraced by social actors on various levels (policy makers, service planners, clinicians, service users). The report further cautions that without careful examination of the evidence for integration, the whole movement can become an "integration reflex" (CECA, 2008), collapsing back on itself and negatively impacting mental health and addiction treatment philosophy.

Another national initiative included an organization of representatives from various sectors to dictate the vision, principles, and priorities for the reduction of harm caused by substance abuse in Canada (The National Framework for Action to Reduce Harms Associated with Alcohol and Other Drugs and Substances in Canada, 2005). The Framework has recognized the need for better integration of specialized substance use services with other health and social services, as well as the importance of adequate funding and evidence-based practices (The National Framework for Action to Reduce Harms Associated with Alcohol and Other Drugs and Substances in Canada, 2005).

Parallel steps taken under the leadership of CCSA with the cooperation of CECA attempted to provide direction in the planning and care of addiction treatment. Both institutions organized a national working group of more than 30 representatives from across Canada—*The National Treatment Strategy Working Group*—that developed the recommendation for a national treatment strategy, with a tiered continuum of services as a key model for addiction services. The strategy recommended that lower tiers with more generalized services should be

made accessible to a larger number of people while upper tiers of specialized services would be accessible only for a small number of individuals with more severe substance use problems (National Treatment Strategy Working Group, October 2008). "The tiers in the proposed model represent different levels of services and supports corresponding to acuity, chronicity, and complexity of risks and harms associated with substance use" (National Treatment Strategy Working Group, October 2008, p. 1). The Working Group endorsed a "no wrong door" policy for the assessment of concurrent disorders (previously proposed by the Manitoba Research Foundation in 2004) and called for improved coordination of services for concurrent disorders in this "tiered model" of treatment systems (National Treatment Strategy Working Group, 2008). However, The National Strategy did not implicitly address treatment of problem gambling or related co-occurring disorders.

In this section, I have demonstrated how the addiction sector has adopted the notion of integration through various national initiatives as a means to achieve better quality of services, while also shaping the institutional environments of the two cases in this study. The biggest change in Ontario, however, has been the restructuration and regionalization of the health care system in the province. The consequences of this for mental health and addiction services are explored in the following section.

5.6 The Shift from Centralized Governing Structures to Regional Health Authorities

The established interim bodies—mental health implementation task forces—were tasked with developing an implementation plan for *Making It Happen,* the provincial framework for mental health reform produced in 1999. These task forces, acting as "local leaders" to coordinate and expedite the restructuration of psychiatric hospitals, were supposed to narrow the gap between the vision and the reality of the reform; the underfunded services had become a "bewildering maze" for clients and their families (Toronto-Peel Mental Health Implementation Tasks Force, 2002, p. 2). However, CAMH found the recommendations of the Toronto-Peel Mental Health Task Force report neglected the issue of concurrent disorders but recommended that "[c]oncurrent disorders should be made a high priority for funding as well policy development by the MoHLTC" (Succeeding in Mental Health Reform: Critical Elements, CAMH, October, 2002, p. 27). Ultimately, in 2002, issues pertaining to mental heath reform were identified in the final report of the Provincial Forum of Mental Health Task Force Chairs and recommended transforming Ontario health care into a system of health networks with regional rather than provincial authority.

On March 1, 2006, the Government of Ontario passed health care legislation (The Local Health System Integration Act) that gave the newly established LHINs the legislative power and authority for planning, coordinating, and funding local health systems. Out of 14 LHINs, 12 recognized the integration

of mental health and addiction services as one of their priorities.[17] Problem gambling services, although organizationally placed in substance use services, are still funded separately. At the time the data was collected for this study, LHINs had been functioning for less then two years and the expectations from the new, restructured system of governance were still not been clearly established. This was felt to be a highly unstable period among clinicians and program management at CAMH:

> *I think we are entering a new era with the regionalization of the province and the LHIN environment and I think it is quite possible that things will change for us in terms of, you know, our accountability and how we as a hospital are managed. So, I think we are entering a bit of uncharted territory and how that's gonna drill down to a frontline clinician...it remains to be seen. Because regionalization of health care is about rationalization of health care and I don't know what that's gonna look like in the next 10 years but it's not been a nice story in other provinces. So, I think there are some risks that lie ahead (P13).*

The concern expressed by this research participant is related to potential changes that may stem from the legislative power of LHINs to integrate services. This could result in closing down services, mergers, or other restructuration that would directly affect the already vulnerable mental health and addiction services during a time when all health care services are competing for their budgets:

> *People still talk "if only they could get rid of them" [LHINs] but it you know it is an active it's a legislative act so, I think they would have to do a heck of lot of work to get rid of them (laughs) (P8).*

[17] Until 2004 Ontario, unlike other provinces, did not have any regional health authorities except for 16 District Health Councils with a limited mandate and practically no control over funding.

On the other hand, the fact that LHINs recognize both the importance of integrating mental health and addictions services and the existence of concurrent disorders themselves has brought stability and the understanding that CAMH is an important influence for its institutional environment. According to Meyer and Rowan (1977/1991) new institutions can be accepted based only on their legitimacy and indoctrinated concepts that are present in wider institutional environment. One research participant clearly identified the endorsement of integrating mental health and addictions by LHINs:

> *If we go to the level of LHINs I think that they're trying to figure out and have just begun. I don't think we have good evidence or bad evidence of what the LHINs are capable or not capable of doing. I think that they've joined the populists and not in bad way but...I think that they've all embraced integration of mental health and addictions being a priority... I think there are lots of words on pieces of paper. I don't think that they've proven themselves yet in terms of whether that's gonna translate into genuine or substantive kind of support (P11).*

Indeed, the Toronto Central LHIN identified mental health and addiction as a central problem within the nine focus areas in its first Integrated Health Service Plan (2007-2010). This is partly the result of successful initiatives and lobbying by CAMH and other mental health and addiction services in Toronto to promote the value of their services. The inclusion of particular services and concepts in the overall health care plan immune to changing governance and funding flow enhances the likelihood of their long-term survival. Wells, et al (2005) report that organizations, particularly substance use services, had greater chances of survival if their directors were involved in policy, which reinforces the role of individual actors in shaping institutionalization discussed by Lawrence and

Phillips (2004). Similarly, one of the research participants spoke about the way CAMH has attempted to influence its environment through the actions of its individual members:

> *Our CEO, myself and others have had several opportunities to go and tell them what we're about and what we have achieved and where we've come from. Being a centre that we are, we come from a background where people had a fair amount of respect for the clinical, academic, policy, education research piece. So that alone has opened for us many doors at LHINs, and in fact we were asked to give input to the shape of the LHINs across the entire province and one of the things we very clearly anchored is that addictions and mental health had to be there coming together and that it has to be...really a high priority in the LHINs...and that has been established (P12).*

The following statement, from another research participant, illustrates the relationship between interests, agency, and institutions in the process of legitimizing the Centre's activities:

> *I am not in the public policy area but there are other people at CAMH and other parts of organization who have spent a lot of time trying to influence policy makers and provide compelling evidence as to why LHINs and policy makers should invest in mental health and addictions and that it is a set of disorders that is as legitimate as cancer and cardiovascular problems and lot of other conditions out there that have a huge impact on population, and I think they have been unrelenting and very successful in what they've done in partnership with the couple of big provincial networks and that's why we have an impact (P13).*

It is evident that the institutional changes in mental health and addiction used by the government as a form of coercive isomorphism have had a profound effect on the integration treatment paradigm. This new development in the Ontario health care system reflects another aspect of the broader organizational environment of my two cases. The next chapter focuses on the

merger that created CAMH and the organizational structuring of the treatment programs, capturing their more immediate organizational contexts. My findings thus far demonstrate the active role of CAMH in the institutionalization of the integrated treatment paradigm through its various activities and associations within the local community, provincially, and nationally.

5.7 Concluding Remarks

In this chapter, I provided data collected on the broader institutional environment of mental health, substance use and problem gambling sectors. I demonstrated that the development of integrated treatment for concurrent disorders has been related to political, ideological, professional, and bureaucratic factors in all three sectors. I identified the main turning points in mental health and addiction policies in Ontario and I also drew attention to the national context of mental health and addiction policies as they related to provincial developments in my cases. The analysis of policy documents has fulfilled two goals: first, it permitted a better understanding of the historical perspective on integrated treatment for concurrent disorders; second, it served as backdrop for the analysis of my findings presented on the micro- level in the next chapter.

Chapter 6:

The Institutionalization of Integrated Treatment Paradigm

Introduction

In this chapter, I will explore the process of institutionalization of integrated treatment for concurrent disorders analyzing the two cases in my study: the *Concurrent Disorders Service and the Problem Gambling Service*. Although the Problem Gambling Service is not profiled as one that provides concurrent disorders treatment, it handles a clinical population that emerging research shows having complex needs related to gambling, substance use, and mental health problems. Therefore it is valuable to explore if and how actual clinical policies and practices in both treatment programs respond to the increased pressure to address the needs of a population with concurrent mental health, substance use, and gambling problems.

My findings as they pertain to the increasingly institutionalized concept of integrated treatment for concurrent disorders shall be presented in this chapter. During my data analysis, the inter-relationship between the broader contextual factors for the treatment programs and their treatment environment became an over- arching approach as distinct but interrelated themes began to emerge.

In the first section, I will demonstrate how integrated treatment, an emerging practice in treatment of concurrent disorders, became institutionalized through the development and diffusion of organizational texts (articles, reports, treatment manuals), symbols, and powerful metaphors. I support my argument

by analyzing the relationship between influential "texts" and actions and by demonstrating how some of the texts acted as catalysts for the integration "movement". I also suggest that creating powerful metaphors and adopting "platitudes" from broader cultural rationalized myths are products of discourse leading to action.

In the second section, I will demonstrate how the broader organizational context of both cases, shaped by the larger structural changes in the health care sector, became interrelated with integration activities on the organizational level. The merger of four specialty hospitals into CAMH helped to legitimize the concept of integration for mental health and addiction systems and services. I will identify the ways that the personal and professional orientation of clinical staff in both programs have helped shape treatment ideologies and vice versa. I will also focus on the ways adopted treatment ideologies provide an overarching framework for the mission, vision, and overall strategies for provided treatment. Treatment ideology serves as a mediator when reconciling the conflicting demands of a changing institutional environment for both programs, a phenomenon I observed during the course of this study.

The next section discusses internal structuring and diversification of treatment services. It provides evidence that both treatment programs, in order to gain legitimacy in their changing institutional environment, engaged in the process of specialization of care. During this process, the individual agency of personnel based on their personal preferences and professional backgrounds helped define the treatment orientation of both programs.

The final theme that emerged from my data is the legitimizing power of evidence-based practices in both treatment programs and the increased emphasis on treatment outcomes that adhered to technically driven treatment efficiency. The conflict between the cost-efficiency and client-centeredness of provided treatment is then examined along with changes in the levels of professional prerogative (discretion) and standardization of care.

The findings of this study indicate that administrative integration of services into one organization does not necessarily promote integration of treatment. I have identified that capacity building activities – particularly those conducted in the CAMH mental health programs – for concurrent disorders became one of the avenues by which integrated treatment has been institutionalized at CAMH. Given the fact that CAMH has an elaborate organizational structure and compartmentalized services, the problems it experiences to some extent mirror the problems present at the systemic level (different treatment ideologies, professional norms of mental health and addiction clinical staff, bureaucratic and financial problems).

6.1 Texts, Language, and Metaphors

Rather than through patterns of action, institutions are constituted through *discourses* that Parker (1992) defines as the "structured collections of meaningful texts" that depict and communicate the actions (quoted in Phillips, et al. (2004, p. 636). The institutionalization of integrated treatment for mental health and

addiction problems can be interpreted through this framework by incorporating created texts, symbols, and spoken words into the daily practices of the two cases under study.

One of the organizational texts that has been instrumental in the institutionalization of the integrated treatment paradigm is the report *Best Practices: Concurrent Mental Health and Substance Use Disorders,* prepared by CAMH's leading clinicians and researchers and coordinated by Brian Rush, a project leader. The report was published as part of Canada's Drug Strategy (Health Canada, 2001) and was one of the first documents that attempted to define systems and program integration. It has since become an informative resource for evidence-based practices in the treatment of concurrent disorders in Ontario and across Canada. It provides a summary of the rapidly increasing amount of research literature, the opinions of experts on integrated treatment, and the views and perspectives of service users (Health Canada, 2001). Free copies of the report were made available online by Health Canada, which then printed more than 30 000 copies for distribution. These were further supported by numerous presentations and workshops given by the CAMH project leader. The high demand for the report from mental health and addiction service providers, policy planners, researchers, and consumers indicated that there was a significant lack of direction when addressing the problems of individuals with concurrent disorders prior to the *Best Practices* reports.

These documents have been able to promote the value of integrated treatment because of their backing from the formal authority of Health Canada

and because they were developed by a team of leading researchers, clinicians, and program managers. This also reinforced the dissemination of clinical practices such as integrated treatment for concurrent disorders to professional audiences by CAMH clinical research and publication activities (e.g., CAMH, Beyond the Label, 2005; Skinner, 2005; Skinner, O'Grady, Bartha, & Parker, 2004). Such texts or documents have since become organizational texts that, according to Phillips, et al. (2004), can be utilized by other social actors as an "organizing mechanism across individual situations" (p. 640). Workshops, seminars, and lectures, including the online training on concurrent disorders developed and provided by CAMH, became part of the training of professionals working in mental health and addiction services throughout Canada. These activities contributed to normative isomorphic change in the field of integrated practices for concurrent disorders across Ontario as well.

Texts

The *Best Practices* report (Health Canada, 2001) provided several arguments for both systems and service level integration. Integrated treatment is not simply clinically effective but also cost efficient. Current service separation is in fact more expensive than the "best practices" of integrated treatment. This inappropriate use of funds resulted in frequent emergency room visits by people with concurrent disorders, repeated hospitalization, and the overall low satisfaction with treatment interventions that were among the feedback communicated across both systems (Health Canada, 2001). Service users with

concurrent disorders provided testimonies recounting experiences and perspectives exemplifying severe stigmatization, the overwhelming need for support and continuity of care, and clients' "immense frustration and anger with being shunted back and forth between mental health and substance abuse agencies" (Health Canada, 2001, p. 72). The frequency of this complaint has been supported by one of the clinicians interviewed in my study:

> *So all of us, from the clinical standpoint have those individual stories, have a belief or knowledge that had that person been accepted in one or the other door or if ideally the person had been accepted in one door with the assistance from the other door, there would have been better services for them and there would have been better treatment outcomes. So, I think there is a definition of integration that is motivated by those stories... (P11).*

Generally, both systems saw themselves as insufficiently equipped to deal with the complex issues of this subpopulation because of conflicting views and treatment ideologies, a lack of cross-training for clinicians, different organizational mandates and structures, as well as different sources funding (Health Canada, 2001).

Integration of treatment for concurrent disorders was strongly supported by available epidemiological data on the high overlap of mental health and substance use problems among this population as it sought treatment in mental health and addiction treatment services (Centre for Substance Abuse Treatment, 2005; Health Canada, 2001; Rush, et al., 2008a). A significant amount of the literature utilized comes from American research on clinical populations with chronic mental health and substance use problems (Drake & Mueser, 2000; Minkoff, 1998; 2001). The main message, based upon the prevailing data from

the 1980s and 1990s, was that concurrent disorders should be the *expectation* rather than the *exception* (Minkoff, 1998; 2001; 2005).

Throughout the previous chapters, I have identified and discussed how the changes to mental health and drug policy in Canada and the United States can be explained through mimetic isomorphism. This same principle applies to the institutionalization of integrated treatment for concurrent disorders. I further expound upon this argument by reviewing the second report on integrated practices and systems (Rush, et al., 2008a) developed by the project leader of the influential Best Practices Report (Health Canada, 2001). In this second report, Rush et al. (2008a) conducted an extensive review of the literature on concurrent disorders and identified three stages in the development of arguments for integration from the referenced literature in North America. The review of professional literature on concurrent disorders provided by this report proves how influential texts promote action. In this specific case, it was the institutionalization of the concept of concurrent disorders and the need to provide simultaneous treatment for mental health and addiction problems that derived from the literature review.

According to Rush, et al. (2008a), the reports written during the "discovery stage" attended to the existence of overlapping mental health and substance use disorders in the general population. Comorbidity was acknowledged more extensively following community studies in the United States by Regier, Farmer, Rae, Locke, Keith, Judd, et al. (1990) and by Kessler McGonagle, Zhao, Nelson, Hughes, Eshleman, et al. (1996).

In Ontario, the high rates of comorbidity among the general population have been reported in a mental health survey by Ross (1995).[18] The data that emerged from the same 1990/1991 mental health survey determined that comorbidity is the major factor associated with treatment-seeking behavior among people with substance use problems in Ontario (Merikangas, Mehta, Molnar, Walters, Swendsen, Auilar-Gaziola et al., 1998; Ross, Lin, & Cunningham, 1999). The argument for the integration of services was further strengthen by American psychiatric studies that identified subpopulations with severe and persistent mental health problems, such as schizophrenia and bi-polar disorders, to be at a higher risk of co-occurring substance use problems (Drake, et al., 1998; Drake et al., 2004; Drake & Mueser, 2000; Mueser, et al., 2003).

Addiction services also reported this high overlap of mental health and substance use problems. In Ontario, the prevalence of mental health disorders among populations seeking treatment at the former Addiction Research Foundation was reported in the study of Ross, Glaser, & Germanson (1988)[19] and corresponded with the growing sentiment towards concurrent disorders from American clinical samples in the 1980s and the 1990s (Minkoff, 2001).

The significance of the American research conducted on this subject leads me to conclude that evidence supporting the notion of overlapping concurrent disorders from the United States became an impetus for acknowledging the

[18] 55 percent of those with lifetime alcohol diagnoses also qualified for a lifetime mental health diagnosis.
[19] 68 percent of clients attending treatment at ARF qualified for concurrent psychiatric disorders such as antisocial personality disorder, phobia, anxiety and depression.

importance of concurrent disorders in Canada. The American research, however, remained associated with "dual diagnosis" and "dual disorders" terminology, particularly by influential scholars in this field (Minkoff & Cline, 2004; Mueser, et al., 2003). In this regard, the mimesis with American research remained persistent in Canadian jurisdictions where the American expertise on concurrent disorders has been used for planning and developing services for concurrent disorders (P7; P19).

Rush et al. (2008a) also acknowledge in the second report the dominant role of American scholarship during the "significance stage". Clinical studies reported poorer clinical and social outcomes when co-occurring mental health and substance use disorders were present (Drake et al., 2004). Economic considerations have also rationalized integration in the United States, particularly in the mid-1990s (Rush, et al., 2008a), unlike the more recent Canadian studies (Somers, Carter, & Russo, 2007; Seguin, Lesage, Turecki, Daigle, & Guy, 2005a in Rush, et al., 2008a). Urbanoski, Cairney, Adlaf, & Rush (2007) reported on the lower satisfaction with care among individuals with concurrent disorder compared to those with either a substance use or mental health problems.

The "solution stage" identified in the report (Rush, et al., 2008a) refers to the literature on treatment research, system-level reports, and policy initiatives. Again, prominent American researchers involved in the treatment of concurrent disorders, particularly for severe mental health and substance use problems, contributed with the development of treatment protocols that have been disseminated throughout the United States and Canada (e.g. Mueser, et al.;

Najavits, 2002; SAMHSA, 2002). The reviews from the "Dartmouth School" on the effectiveness of integrated versus non-integrated treatment were also part of this solution stage (Drake, et al., 1998; Drake, et al., 2004; Drake & Wallach, 2000; Mueser, et al., 1998). The aforementioned authors have championed the development and dissemination of the integrated treatment model for severe and chronic concurrent mental health and substance use problems through multiple channels such as conference presentations, research texts and reports, training modules, consultations, and workshops. Their influence has been felt in Canada, as noted by one research participant:

> *Some places hired Ken Minkoff from US. Now he has a CD corporation, he does a lot of training and it is very, very expensive. Some people like the product some don't like the product. So, he is another part of the research knowledge exchange process that is outside of public centre... But he comes from this Dartmouth School with strong, strong credentials (P7).*

In Canada, the literature on clinical research has also grown. The Canadian studies of Charney, Paraherakis and Gill (2001) report positive outcomes in the treatment of co-occurring substance use problems and depression when mental health and addiction treatments are integrated; Korman, (2005) and Korman et al. (2006) report on the superiority of integrated treatment for co-occurring anger, substance use, and gambling problems to standard treatment programs. The research compiled by both American and Canadian studies demonstrate how research texts and reports and their distribution became part of organizational discourse and how they contributed to the institutionalization of the integrated treatment paradigm in Ontario.

On the system level, the initiatives of the Centre for Substance Abuse Treatment's *Treatment Improvement Protocol* (2005) and the Substance Abuse and Mental Health Services Administration's *The Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit* (SAMHSA, 2003) contributed to the diffusion of evidence-based knowledge on integrated treatment of concurrent disorders in the United States. In Canada, the most influential text was the above-mentioned report *Best Practices, Concurrent Mental Health and Substance Use Disorders* (Health Canada, 2001). The report, for the most part, summarized the studies from American scholarship on concurrent disorders. Canadian input was obtained from the membership of an Expert Panel across Canada who reviewed and advised on the work of the project team lead by Dr. B. Rush.

The epidemiological evidence on concurrent disorders presented in the *Best Practices* report (Health Canada, 2001) has been re-examined in the light of more recent Canadian population studies (Rush, Urbanoski, Bassani, Castel, Wild, & Strike, et al., 2008) as well as the studies of clinical populations (Castel, Rush, Urbanoski, Toneatto, 2006; Rush & Koegel, 2008). The new Canadian population data summarized by Rush et al. (2008a) show that, in a broad sense, the overlap of mental health and addiction problem based on their prevalence in the past year was 15-20 percent, compared to 20-40 percent reported by earlier studies (Rieger et al., 1990; Kessler et al. 1996; Merikangas et al., 1998); life-time prevalence of concurrent disorders among the general population in Canada does not exceed 40-50 percent compared to earlier American and Canadian

studies that reported more than 50 percent (Kessler et al.,1996; Rieger et al., 1990) for all disorders combined. Rush et al. (2008a) also reports that the Canadian data has identified that co-occurring disorders are present as a rule in the majority of patients seeking addiction services and is congruent with other American and Canadian studies, but is less prevalent among individuals seeking treatment in mental health services (Rush & Koegl, 2008).

As the authors of these studies themselves acknowledge, differences in methodology, including more accurate protocols for assessing concurrent disorders, could likely contribute to variations in the interpretation of the data. The extensive review of epidemiological data by the authors of the second report (Rush et al., 2008a) communicates that there needs to be clarity in data reporting when intending to argue for treatment integration:

> *[G]iven the most recent data on the level of co-occurring disorders in Canada (and the US for that matter), it is time that data producers and data users got past the simplistic mantra of 'co-morbidity is the rule rather than exception', and used the data most appropriate at both the population and clinical level in support of service and system planning. This should include a strong emphasis on reporting by sub-population, including level of severity* (p. 29).

This cautionary reminder confirms that certain concepts are accepted because of their legitimacy and organizations incorporate these concepts into their mandates and policies to become isomorphic with their institutional environment.

Rush et al. (2008a) states that the second report can be considered a "follow-on" document to his *Best Practices* report (Health Canada, 2001). After

reinterpreting literature on the prevalence of concurrent disorders, the authors conclude that the majority of people with either mental health or substance use disorders do not have concurrent disorders[20]. They also reflect on their role and the role of other professionals who "have seemingly fallen into their own 'silos' of sorts and failed to draw upon many other areas of work of potentially of high value" (Rush et al., 2008a, p. 86). The rationale for large scale integration should not, according to the second report, be solely based on epidemiological data supporting the high overlap of mental health and substance use problems.

I used the second Canadian report developed by Rush et al. (2008a) as an example of the relationship between organizational discourse and the institutionalization of concurrent disorders. Although the review presented on epidemiological evidence could be a subject of possible interpretative bias, summarizing Rush et al (2008a)'s review was not the main aim of my review. Rather, I want to demonstrate that the organizational texts and their authors can contribute to the institutionalization *and* to the de-institutionalization of particular phenomena. The discursive authority of governments, research-based organizations, or individual actors with high credentials can help create and disseminate texts that become highly influential. As Philips, et al. (2004) describes it, such texts leave the "traces" and help create legitimate knowledge institutions.

[20] In this case, I purposefully use the terminology of the report although "mental health or substance use problems" would be the preferred term within the social work paradigm.

Metaphors

One of the most important aspects of isomorphism within the institutional environment is the evolution and adaptation of "new" organizational language (Meyer & Rowan, 1977/1991). For example, referring to the overlap of mental health and addiction problems as "rule rather than exception" (Minkoff, 1998; 2001; 2005), has become a rationale for the integration of treatment for concurrent disorders. More importantly, this axiom had become so pervasive that it also serves as a rationale for some to call for the integration of services for any type of comorbidity, regardless of the level of severity and chronicity of the mental health and substance use problems (Rush et al., 2008a).

Similar to the "rule rather than exception" adage, the isolation of both systems expressed through the symbol of "two silos" is also evident from the available organizational texts (Health Canada, 2001; Kirby, 2004a) and was reiterated by a member of program management:

> *Research and professional literature identified that about 60% of mental health clients have concurrent disorder and the silos of mental health and addiction systems were not conducive to get(ting) client care (P13).*

The "silo" metaphor, also used by the Kirby Committee (2004), has become a powerful argument for integration and has trickled down to the organizational and clinical language of both sectors. Used in the context of these two systems, "silo" has a negative connotation and represents isolation as well as an uncooperative relationship between the mental health and addictions

sectors. One of my study participants, however, acknowledged the adaptation of this concept as one of the overused metaphors accepted in everyday practice:

> *I think that, again, it's one of those sacred cows...to say silo is to invoke negativity. To say multi-disciplinary is to invoke like a holy value, and so, I value it a lot actually but I think it's important to look at how it's operationalized (P19).*

The silo metaphor is an example of the way organizational language becomes accepted and utilized in the institutionalization process without questioning its meaning. Czarniawska-Joerges and Joerges (1990) state that ideas or concepts become objects by turning into "linguistic artifacts by a repetitive use in unchanged form, as in the case of *labels, metaphors, platitudes"* (quoted in Czarniawska & Joerges, 1996, p. 32). The authors further illustrate this using the example of how "words are turned into labels by frequent repetition in an unquestioning mode in similar contexts, so that possible 'decentralization, why?' will give way to 'decentralization, of course!' and therefore decentralization will become what we happen to be doing in our organization" (Czarniawska & Joerges, 1996, p. 32).

The metaphors and labels are adopted from broader cultural rationalized myths (Phillips, et al., 2004). In this instance, the notion of integration as metaphor or platitude is understood as a measure leading to efficiency, rationalization, and innovative practices. These broad (or generic) socially rationalized myths, which are transmitted into an organizational context, have become an organizing principle for new institutions created as part of the integration treatment paradigm. In the case of "silos", however, as one research participant (P19) noted, their positive function in agriculture as resource storage

has been completely ignored and the metaphor has come to symbolize isolation, and integration can only be achieved by their destruction. Every attempt to do so is therefore highly valued; for example, on its internal website CAMH presents and highly values the activities that strengthen or increase cooperation between its mental health and addictions programs. In my field notes from a staff meeting (May 29, 2008) at one of the clinical programs, a staff member responded with distinct sarcasm to an initiative that would include cooperation with other programs as a way of gaining recognition on an internal web page as a "silo-buster". This sarcasm reflects the rejection by some staff of the perception of "silo-busting" as an achievement or goal with any practicable merit.

The neo-institutionalism concepts suggested by Meyer and Rowan (1977/1991) can be useful for interpreting this incident. The destruction of silos is first adopted ceremonially as a metaphor representing an activity helping to achieve integration. Second, the whole concept is perceived as a factor contributing to the greater legitimacy of the team or program but not necessarily something that guides organizational activity and change. Zucker (1987) asserts that organizations readily accept and disseminate legitimized principles or practices if they include the prospect of improving the organizational reputation of involved social actors. Adapting legitimized practices has symbolic dimensions that require policy makers, service planners, researchers, and clinicians to engage in the dissemination of specific organizational language, including metaphors, labels, and platitudes. In this way, staff and other social actors become instrumental in the institutionalization of newly adapted organizational

practices without necessarily questioning their meanings. One of my study participants, further reflecting upon the use of the "silo" metaphor affirms this theoretical construct: "*It's become so stereotypic(al) for people to have this, the silo-busting reflex...it's actually become thoughtless*" (P19).

Integration of mental health and addiction services on the organizational level within CAMH has been highly endorsed and this is evident from the formal appraisal of such clinical activities as becoming a "silo buster". This, however, has since been challenged by the personal accounts of two participants; one perceived the measure as highly formal and symbolic, while the other questioned the rationale for using this metaphor to representing solely a negative aspect of both systems. P19 rather emphasized the "positive" sides of silos; that their destruction would mean losing valuable resources.

Specific organizational language, organizational symbols, texts, artworks, pictures, buildings, and other artifacts are all instrumental in institutionalization processes (Philips, et al., 2004). For example, in the June 26, 2006 celebration of the 10th anniversary of CAMH, pedometers with the organization's logo served as symbols of the organization's successful journey towards integrating both mental health and addiction services since its inception. The anniversary was celebrated with the grand opening of the services that are part of the first phase of the redevelopment of the Queen Street site. The redevelopment project aims to integrate mental health and substance use services by moving the existing CAMH programs into the same physical location. This is based on the assumption that relocating the programs and services into a newly created

"urban village" will reduce their fragmentation and reduce stigma for clients (www.camh.net). According to the CAMH website, "silos between addictions and mental health treatment will come down as CAMH's programs come together at the Queen Street hub....CAMH's Addictions Program will be fully integrated at the Queen Street site, and no longer split between different locations. The co-location of addictions and mental health professionals will lead to increased collaboration between CAMH staff and better results for clients, particularly the 40 per cent who have both disorders concurrently" (CAMH, n.d.) Re-development also aims to present mental health and addiction treatment services in a more appealing way and reduce the stigma exacerbated by the existing institutional character of the former Queen Street site. Along with the redevelopment project and the high presence of media and government representatives at various occasions, the "Transforming Lives" awareness campaign has become another means to address stigma and draw more attention to CAMH's services. The campaign uses the personal narratives of individuals with mental health and substance use problems or their family members, some of whom are well-known public figures. The stories of recovery are presented in print media (Toronto Star, May 2008 – November 2008; The Globe and Mail, November 2008–February 2009) and as ads on bus shelters or through TV and radio spots. These stories, along with the award given to individuals recovering from mental health or addictions (The Courage to Come Back) have become part of the newly created discourse to demonstrate, seek public approval, and consequently secure government support and funding for the unstable institutional conditions of

mental health and substance use sectors. Creation, dissemination, or "translation" of texts, symbols, metaphors, logos, and buildings have helped facilitate the institutionalization processes on multiple levels (policy, organizational, individual) and are able to reach different audiences with their legitimizing message. The theoretical argument of Philips, et al. (2004) on the importance of organizational language, texts, and symbols as and integral part of the institutionalization of particular phenomena, provides a framework for interpretation of the institutionalization of integrated treatment.

6.2 Responding to the Changes in Institutional Environment

The collected data suggests that integrated treatment for concurrent disorders at CAMH became part of the much larger institutionalized myth on the integration and rationalization of the provincial health care system. During the merger, the need for an integration of services for concurrent disorders had already been discussed at the national and provincial levels. For example, the joint initiative of the Mental Health Division and Alcohol and Other Drugs Programs of Health Canada (1996) attempted to bridge the gaps between the two systems by emphasizing the common environmental and psycho-social basis of mental health and substance use disorders. Emphasis was also placed on the existence of frequent overlaps in both systems. On the provincial level, lack of integration between and within the two fields was a prevailing argument for the

improvement of services for concurrent disorders (The Canadian Mental Health Association, Ontario Division's Task Force on Concurrent Disorders, 1997).

In 1998, four specialty institutions were amalgamated into one specialized institution. Here is an account of the events according to one study participant who experienced the merger:

> *In the late 80s[21] the provincial government of that time created the Health Services Restructuring Commission and that Commission was struck to look at integration of hospitals to try to come up with more, I guess, rational and efficient way of operating a very expensive sector of the health care budget. And at that time the Clarke Institute was involved in the discussions with the provincial government about whether there were opportunities to integrate mental health and addictions providers. And at the same time, philosophically, out of the literature there was an identification of the fact that about 60% of mental health clients have co-occurring substance use issues and the silos of mental health and addiction weren't conducive to get client care... and basically the series of very confidential negotiations took place between the Clarke, the Donwood, the ARF and the Queen Street and ultimately the provincial government have made the decision to integrate the four and that's...it was all part of health services restructuring (P13).*

According to Garfinkel, Simpson and Baumann (1999), this merger was a reaction to the nation-wide inquiry into healthcare systems carried out by each of the individual provinces in the late 1980s and early 1990s. These findings indicated that health care needed substantial improvements. At the same time, attempts to reform Ontario's mental health system were fuelled by epidemiological data showing tremendous unmet needs in this area, along with

[21] In fact, HSRC was created in the beginning of the 1990s but the consequences of its mandate were felt later in that decade by the merger.

systemic problems in service delivery (Garfinkel et al., 1999)[22]. As the authors recall, before the merger, the Clarke Institute of Psychiatry and the Queen Street Mental Health Centre had already discussed sharing some support services to reduce their expenses. Later on, the mandate from the Government allowed the HSRC to merge two addiction services - the Addiction Research Foundation and the Donwood Institute - into one organization along with the Clarke Institute and the Queen Street Mental Health Center. Mergers were very common in the restructuring efforts taking place across the nation; the publication by Canadian Health Services Research (2002) called 1990 and 1999 the peak of "merger madness", where the number of Canadian hospitals declined from 1,231 to 929, a drop of almost 25% (though mergers were certainly not the only factor contributing to this change) (Canadian Health Systems Research Foundation, Myth Busters, 2002).

Building and Maintaining CAMH's Legitimacy

In its 10-year anniversary report, CAMH reflected on its first decade by highlighting successes in integrating mental health and addiction services and in uniting five different mandates: clinical care, research, education, public policy, and health promotion (Report to the Community 2007-08). CAMH's strategic plans (the first was approved in 1999) underscored the need to develop and implement integrated treatment for concurrent mental health and substance use disorders (CAMH Strategic Plan, 2003/06; CAMH Strategic Plan, 2006/09).

[22] Three people out of four who needed mental health or addictions services did not receive care at all.

Moreover, CAMH was mandated to "develop programs and service models for dissemination to the field [and] develop treatment programs to meet the needs of people with concurrent disorders, youth and other populations", and to "provide a provincial training program for addiction staff working with people with concurrent disorders" (*Setting the Course,* Ontario Substance Abuse Bureau, 1999, p. 25-26).

In their study of institutional entrepreneurship in emerging organizational fields, Maguire, Hardy and Lawrence (2004) claim that organizational characteristics, such as a wide geographic scope or, in the case of CAMH, its provincial mandate, addressing the needs of diverse groups, as well as clients with a large scope of mental health and addiction problems, with the location of the organization in a large urban area contribute to greater legitimacy for an organization. Prior to the merger, the four amalgamated organizations had different organizational cultures, professional norms, and clientele, all of which were brought into a newly established multi-service organization. The ARF, for example, held a strong position in the Ontario addiction sector as a hub for clinical practice and research, and was an active participant in policy planning and consultation (Ministry of Health, 1993). Taking part in creating a new Canada Drug Strategy (Health Canada, 1993) and fully aligning its research and clinical activities with the Strategy's main concepts (ARF Strategic Priorities, 1993/4 and 1994/95; October 18, 1993), the ARF maintained its status throughout the structural changes to the sector in the 1990s. One of its priority areas was the project for "people with mental disorders and addiction problems"

(ARF Strategic Priorities, 1993/4 and 1994/95; October 18, 1993). The ARF's focus upon the treatment of concurrent disorders has remained a significant part of the services since the amalgamation. A small Concurrent Disorders Service at the ARF, which was initially more of a "research device" (P19) than a clinical program, was reorganized into a more ambitious outpatient service in 1996 and provided the platform for the Concurrent Disorders Program in the new Centre. One of the research participants noted:

> *I think that step was taken in the ARF in Ontario and I think that sort of triggered or was a catalyst in making a bit of shifting that weight... By the time CAMH started there was a well established concurrent disorders program at ARF. So, you know in some ways this was ....the CAMH inherited integrated services (P19).*

Another research participant also confirmed the role of ARF in raising awareness about concurrent disorders:

> *Back in 1990s the former ARF set up a tiny concurrent disorders service ... and in terms of...that service had the influence on raising awareness from internal to other CAMH services, as well at the agencies in the field, around the importance of treating both conditions at the same time (P13).*

The emphasis on concurrent disorders had been sparked by earlier Canadian research by Ross, Glaser, and Germanson (1988) who found that 84.2 percent of clients seeking treatment for alcohol or other drug problem at the Addiction Research Foundation had lifetime psychiatric disorders and 68.4 percent had a current mental disorder at the time of treatment. The need for integrated treatment was validated by the needs assessment conducted by the ARF through a provincial survey among mental health and addiction service

providers and by focus groups held for service users (June 1995 – March 1996). The subsequent report based upon this survey recommended the integration of both systems and additional services for people with concurrent disorders such as training and cross-training for clinical professionals, the development of standardized screening and assessment tools, and the evaluation of existing approaches to treatment of concurrent disorders (Melinyshyn, et al., 1996). Although the Addiction Research Foundation played an important role in the addictions sector in Ontario, Room (1999) asserts that, along with other addiction services, it experienced financial cuts during the recession in the 1990s; the ARF budget "shrank by more than one-third over a period of six years" (p. 1782). According to the author, the cuts were proportionally greater than in other institutions due to its size and lack of focus (Room, 1999). Prior to rationalization and consequent financial cuts in the 1990s, the central position of the ARF as a an internationally reputed provincial agency with a multi-focal mandate in research, prevention, treatment, and education for addiction was reinforced by having the second largest budget in the Ministry of Health's Community Mental Health Branch (OSAB, Ministry of Health, background document, 1993)[23].

This is congruent with the resource dependence theory (Pfeffer & Salancik 1978; 2003) and institutional theory (DiMaggio & Powell, 1983/1991; Scott, 2001; 2008) that claim that the legitimacy of an organization is associated with a more effective flow of funding, which in turn increases the likelihood of its survival as an organization (Wells, et al., 2005). The high level of the ARF's

[23] In 1992/1993, the ARF had the second biggest budget provided by the Ministry of Health: $ 36.5 million - $12.9 million for health promotion/ prevention and 23.6 million for treatment.

legitimacy could have been the contributing factor that saved it from complete closure and allowed it to become an important advocate for addiction research and treatment during and after the merger into CAMH. The Addiction Research Foundation's active participation in policy-making helped to alter the institutional environment it was embedded in, allowing the organization to gain more control over its fate (D'Aunno, 2006).

In addition to the delivery of clinical practice for people with mental health problems, the former Clarke Institute of Psychiatry, established as a provincial center for psychiatric research in the mid 1960s, was also active in research and policy-making prior to the merger (Garfinkel et al., 1999). The team of researchers from the Health Systems Research Unit played a leading role in conducting a project focused on the identification of the best practices in mental health reform and strategies for their implementation, focusing upon clients with severe mental illness (Health Systems Research Unit, Clarke Institute of Psychiatry, 1997).

The Donwood Institute, a clinical facility established in the 1960s, provided medical treatment for alcohol and drug abuse, and was reputed to be a very efficient clinic for medical detoxification, residential treatment, and outpatient programs (Garfinkel et al., 1999). The Queen Street Mental Health Centre with its 150-year history of expertise in the care of chronic mental problems had been a Provincial Psychiatric Hospital operated by the Government of Ontario until the merger (Garfinkel et al., 1999; www.camh.net).

6.3 Treatment Ideologies

In this section, I will present and analyze the role of treatment ideologies in the institutionalization of integrated treatment for concurrent disorders within the studied programs. Treatment ideologies, shaped by individual beliefs, professional orientation, and previous work experiences are interrelated with the changing institutional environments where the programs are embedded.

Scheid (2004) defined treatment ideology as "the complex set of beliefs health care providers hold about mental health, illness, and treatment" (p. 42). Treatment ideology serves as an important function to legitimize existing practices and structural arrangements. Accordingly, treatment ideologies are specific to organizations or other collectivities and impact what services are provided and by whom; they are co-constructed from the perceptions and interpretations of reality of various social actors, and are the outcome of interpersonal negotiations between individuals within organizational frameworks. Treatment ideologies however, cannot be entirely reduced to individually held beliefs and actions (Fine, 1984; Levitt and March, 1988 quoted in Scheid, 2004). In the case of CAMH, with its multiple mandates – clinical, research, policy, health promotion, and knowledge exchange - the scope of treatment ideology has broadened as a result of the need to fulfill these different mandates

In this section, I will examine how these mandates, as a result of merging four different organizations, contributed to the formulation of a treatment ideology that provides an overarching framework for diverse practices. The treatment

programs under consideration are placed within a larger organization and inevitably became part of the institutionalization of treatment ideology of CAMH.

In the next section, I will discuss how the ceremonial adoption of CAMH's treatment philosophy by two of its constituent programs maintained a variability of treatment goals.

The concept of treatment ideology helps define the vision and mission of treatment services and formulate the goals of therapeutic interventions and is therefore vital to this study. Treatment ideologies specify the professional roles of clinical staff - who receives treatment and who provides what kind of work - and they are defined by external organizational environments as well as by the individual beliefs of clinicians involved in treatment (Scheid, 1994; 2004). Hasenfeld (1992a) and D'Aunno (1992) state that treatment ideologies are particularly important in human service organizations because of ambiguous technologies and weak, inconclusive measurements of the effectiveness of provided services. At the same time, treatment ideologies serve to mediate the conflicting demands of the institutional environment and help an organization maneuver the inconsistencies between organizational structures and treatment goals (Scheid, 1994; 2004).

Formulation of the New Treatment Ideology

According to Meyer (1986), amalgamated organizations bring different treatment ideologies, ingrained in their organizational cultures and structures, into a newly established organization. Inevitably, the four organizations that

became CAMH encountered disruption to their organizational boundaries and an unfamiliar power distribution among the different professional groups. In the case of the CAMH merger, the Clarke Institute of Psychiatry dominated with a greater role and more power brought from the mental health sector and "had the upper hand in the whole process" (Field notes, June 18, 2008). Because mental health was a larger system that had better access to resources than the addiction system, the Clarke Institute of Psychiatry was also closely affiliated with the strong academic community at the University of Toronto and held an important position in the provincial mental health care system due to its existing research portfolio (Field notes, June 18, 2008)

In the addiction sector, the successful counterpart of the Clarke Institute of Psychiatry was the former ARF, an internationally recognized organization in basic, social, and clinical research and an adherent to evidence-based practices in substance use treatment. Both organizations "easily found common language" (Field notes, June 18, 2008) and became instrumental in defining the vision, mission, and overall goals of CAMH. The mental health perspective, represented by the Clarke Institute of Psychiatry and the Queen Street Mental Health Centre, brought in the recovery approach for mental health problems. The recovery model has moved beyond mental health symptoms and deficits to the most fundamental premise in the recovery paradigm, that "people can and do recover" (Carpenter, 2002). CAMH itself endorsed and funded the launch of the empowerment project in 1999 (www.camh.net) that resulted in the initiation of two formal councils focused on representing clients: the Empowerment Council

and the Family Council; subsequently the Bill of Clients Rights was created. Both councils are part of the CAMH and some of their representatives are CAMH employees.

In the addiction sector, the recovery concept - associated almost exclusively with 12-step fellowship such as Alcoholics Anonymous - is part of abstinence-oriented treatment services instead of the harm reduction model that is associated with an increasing number of empirically supported interventions (Csiernik, 2003a; Laudet, 2008). Abstinence programs, rooted in the disease model, are associated with punitive policies for alcohol and drug use and abuse in North America; abstinence is consistent with the legal framework of drug policies enforcing adherence to this principle (Clapp & Burke, 1997). On the other hand, the harm reduction model, which is a more liberal and public health oriented approach, focuses upon the harm caused by drug abuse rather than directing efforts to the solution of substance use problems via abstinence (CAMH and Harm Reduction: Background Paper, 2008; Clapp & Burke, 1997; D'Aunno, Sutton & Price, 1991; Erickson, 1995; Hathaway & Erickson, 2003; McCann, 2008; Riley, Sawka, Conley, Hewit, et al., 1999; Single, 1995; 1997; 2001).

Developing the new treatment orientation for CAMH's Addictions Program was described by one of my research participants as follows:

> *I think addiction is understood as a health condition that requires harm reduction framework and there was a big debate at the point of the merger...it was not a debate...they had an academic review of what would the philosophy of care be within the Addictions Program. Would we adopt the abstinence model or the harm reduction model? (P13).*

This quote illustrates how the legitimizing power of evidence-based practices, focused by existing discourse in addiction research, served as a rationale for adopting harm reduction treatment therapies. While the Addiction Research Foundation was oriented towards harm reduction and the former Donwood Institute was more abstinence-based, the result of the amalgamation was the formulation of a treatment ideology that utilized the harm reduction approach as an umbrella term encompassing a wide spectrum of treatment goals, among which is abstinence:

> *...it was very clear that we adopted (the) harm reduction model of which one of the choices of a client is abstinence but it is not their only choice...and that really permeated all the service delivery and philosophy of care that we've had ever since (P 13).*

Despite the recognition that the harm reduction and abstinence oriented models could become a "polarized controversy" (Khantzian, 2006), incorporating both approaches into one complementing treatment ideology served the organizational purpose required at the time. The main principles of the harm reduction model assert that society should attempt to help deal with and minimize negative consequences of problematic substance use. Establishing a hierarchy of achievable individual goals can lead to healthier lives for people using drugs as well as healthier communities (CAMH and Harm Reduction: Background

Paper, 2008; D'Aunno, Sutton, & Price, 1991; Erickson, 1992; 1995; Hathaway & Erickson, 2003; MacPherson, 2001; MacPherson et al., 2006; McCann, 2008; Riley, et al., 1999; Single, 1995, 1997, 2001). The harm reduction model finds the abstinence model limited in its scope and, in general, insufficient for dealing with the complexity of problems related to street drug use. The abstinence model is less sensitive to different individual abilities, resources, or willingness to abstain from further drug use. As a result, this can place different populations with addiction problems under a spotlight and they may appear to lack the effort necessary to justify society's intervention. Both models also differ in the way they empower the populations they serve; the harm reduction model is more respectful to an individual's right for self-determination while the disease model imposes its authority upon an individual.

Considering the broader organizational context of the programs, adopting the harm reduction model allowed the amalgamated organizations to retain their clientele. As well, it allowed them to comply with and gain support from different audiences in their changing institutional environment. For instance, the former Donwood Institute served a more extensive population that included people requiring residential treatment from across Ontario and beyond.[24] These individuals needed to be abstinent while in treatment, and would, in almost every case, have long-term abstinence goals: "you can't have people using while they're in residence, right? So, I would say they were more abstinence based at the Donwood at the point of the merger but they were dealing with a different

[24] The Donwood Institute did offer day programs for Toronto-area residents who had sufficient social support to benefit from day treatment.

population" (P13). In contrast, the Addiction Research Foundation had offered outpatient or other low-threshold interventions for inner-city, marginalized populations. The harm reduction approach recognized the need to address concurrent disorders as complex co-existing problems:

> *....at CAMH, as in some other organizations, we've moved away from the abstinence model to a harm reduction model and I think the harm reduction model is more in keeping with understanding mental illness and addiction and that they can coexist and they can be concurrent disorders (P12a).*

Further, the harm reduction ideology has permitted planning and justification of treatment for individuals with concurrent disorders with flexible, individualized treatment goals:

> *We had to make that shift in ourselves as practitioners just to say that there is not much point in talking about total abstinence to a person who has a serious underlying depression and who actually was taking the alcohol or drugs to get some relief to the symptoms of depression ... it is kind of... as you lift out those layers of what's behind them, people then become much more comfortable if they're supported to talk about their depression, or their voices or their stress or anxiety disorder or if there are other symptoms of their illness that are negative and they're trying to mask... (P12a).*

The establishment of the Concurrent Disorders Service as a specialized program for people with concurrent mental health and addiction problems represented a shift in the approach to this population: rather than accepting them for care *in spite of* the complexity of their problems, which was the practice in most of the non-integrated services, they were being offered care *because of* the complexity of their problems (Skinner, 2005). The heterogeneity of the population posed a challenge in accommodating their complex needs within treatment

programs with narrowly defined treatment goals. This made the Concurrent Disorders Service with the harm reduction model and only a few excluding criteria an accessible option for those clients who were easily excluded from mainstream programs:

> *So... originally we were... we set ourselves up as a program that was willing to take all comers... we really thought the problem in most programs is these individuals get excluded as soon as they get identified... and so we thought we want to include them intentionally and... that means we will be willing to work with a very heterogeneous set of people... (P19).*

In the treatment of problem gambling, the Problem Gambling Service originated from a pilot organized by the Ministry of Health in the former Donwood Institute prior to the merger: "it was the first funded gambling treatment program in Ontario. It was when it was at the Donwood's" (P19). It then defined its services as harm reduction-oriented once it became part of the CAMH. One of the clinicians recalled the process of changing the treatment orientation of the program after the merger:

> *In a way you're leaning into what a standard is...because what we were carrying from the US was a lot of GA [Gamblers Anonymous] ...and the disease model. But here, it is not what we do and in fact, at the Donwood, it would be a little bit in line of abstinence based (model) ... and we have been kind of innovative, focusing on harm reduction ...uh... because we started up at the Donwood and it would be a little bit in line of abstinence based ... while here we're trying to be ahead of the game (P1).*

This quote illustrates that the shift towards the harm reduction model was a result of negotiations among participating organizations, and at the same time,

applied the models previously developed for the treatment of substance abuse problems:

> *I think a lot of work we do or have done or even from the beginning when the gambling program was designed and developed...we wanted to learn from substance abuse programs, we wanted to learn from them and lot of information, a lot of the concepts and theories is brought from substance abuse programs (P5).*

Such a modeling activity - referred to as "interdiscoursivity" - is defined as the susceptibility of a particular institutionalized practice to changes in other, related fields or to broader discourses that span multiple fields (Phillips, et al., 2004, p. 647). Use of the harm reduction model in many fields, including problem gambling, is a good example of this concept.

Adopting the New Treatment Ideology

This section discusses the role of personal beliefs and professional training in the process of adopting the new treatment ideology. According to Scheid (1999; 2004), personal preferences for treatment ideologies, shaped by professional training and socialization, influence the way mental health services have been developed and provided. In the case of ideologies that guide clinical work, Scheid (2004) asserts that although they are important, the "official" treatment philosophy of a service provider is not necessarily reflected in the individual beliefs held by clinical staff, and vice versa; the individual beliefs of clinicians can be disregarded by the organization.

The harm reduction model as a treatment ideology of CAMH allowed clinicians with different theoretical orientations to coexist in the same location, a phenomenon that is very common in human services organizations that have to adapt to conflicting institutional environments in order to survive (D'Aunno, Sutton & Price, 1991; Meyer & Rowan, 1977/1991; Peyrot, 1991; Scheid, 1999; 2004). CAMH clinicians were then able to embrace a variety of theoretical approaches to addiction. I witnessed how substance abuse problems were discussed and dealt with using various conceptual frameworks. For example, addiction was discussed as a symptom of underlying, deeper problems (personal, social, economic); as a disease whose treatment is informed by twelve-step model credos ("One day at a time", "Keep it simple"), or as a human action that should and could be conducted with reduced harm to the individual and society. The diversity of addiction treatment approaches are related to ambiguous technologies dependent on interpersonal interaction and the high level of subjectivity among clinical personnel (D'Aunno, Sutton, & Price, 1991).

In my two cases, harm reduction as a new treatment ideology was implemented by a tedious process of engaging clinicians in activities aimed at acquiring the "desired" therapeutic orientation through supervision, training, and socialization. This was endorsed by management:

> *It was just kind of a really long commitment, that kind of change. The leadership was very committed to it and they supported it, so you wouldn't have a situation where, if you were working with a client, the leadership wasn't on board with the change of the philosophy of care. I think the leadership was very much on board...and it just took a lot of repetition and over months and years of reinforcing some of the stuff with the clinicians. Some people got it some didn't, you know, and they just decided this wasn't their place to work. So, people made their choices (P13).*

P13 illustrates that the institutionalization of organizations can become very persistent in terms of their treatment orientation and in their attempts to influence the beliefs and professional orientations of their employees. This is congruent with the *homogenization* hypothesis, a concept that recognizes the power of organizations in shaping clinicians' beliefs and professional orientation (Findlay et al., 1990 quoted in Scheid, 2004). Employees, whose perspectives do not fit within the organization's mission leave that organization to seek "like-minded" organizations to work in. On the other hand, clinical personnel's training and previous clinical experiences are, according to the *importation hypothesis,* the driving force behind formulating an organization's treatment ideology (Scheid, 2004). For example, in CAMH, the former Addiction Research Foundation has been vital in bringing insights leading to harm reduction, thus influencing the programs that provided treatment of addiction problems. However, changing clinician views and beliefs when adopting harm reduction as the treatment ideology is an ongoing struggle:

> *There is still the debate amongst clinicians... Because if you are a clinician who was trained twenty years ago that (the) abstinence-based model is the model that works for people, and you have an AA philosophy and that's what you were trained in and that's your belief system, it is pretty darn difficult to shift a clinician who truly believes that the abstinence-based models are the only way to go. Because we have done that here and it was difficult. People got there eventually, but shifting clinical practice and clinical belief system is a really, really difficult change management (P13).*

This is related to the reality that treatment ideologies of mental health problems and addiction are deeply rooted in societal value systems and the moral assumptions about mental health and addiction. The above quotation also illustrates the point Scheid (2004) made in her study of community mental health providers regarding the adoption of treatment ideologies by staff; practitioners tend to retain their "own" models of care even if these are not congruent with the organization's vision. In Scheid's study, however, treatment ideologies were not systematically endorsed and indoctrinated into clinical practice as they were in the organizational environment of my two cases. The findings of my study suggest that when organizations make an effort to change treatment philosophies, some staff ceremonially adopt the changes if they do not have other options.

Since the relationship between an employee and an organization invariably changes, it is a challenging task to identify the primary source of treatment ideology. Therefore, I shall attend to the interrelationship between clinical workers and the organization they work in by focusing on the data presented in other sections. Through my two cases, I explore how diversity of

institutional environments has posed different demands upon the delivery of services in both programs, and vice versa: how individual preferences, knowledge, and professional interests of clinical personnel have shaped the institutional environments of both treatment programs.

A good example is the Problem Gambling Service that, due to different demands of its institutional environment, did not experience the same budget constraints as services for people with substance use problems typically do. This is related to a more lenient programmatic structure of problem gambling treatment and, in its initial phase, the relative freedom to offer a more individual mode of treatment services. The relative stability in funding flow for prevention, treatment, and research in the area of problem gambling did not exert pressure for services to be provided at greater cost-efficiency as in the case of substance use treatment. Derived from a legal leisure activity promoted by the government, gambling revenue has been used to generously fund treatment of its problematic form:

> *They're more favourably funded. They're living in a privileged world. They don't know it actually or if they do know it, they're not prepared to admit it. And so, they've have it easy in a lot of ways, they – unlike substance use services, they were – you know there was a high demand for their services from above ... even before they were created. (P19).*

Another participant also commented on the availability of resources: "because it is gambling, there is a lot more money in the gambling system, right?" (P17). The Problem Gambling Service, characterized as "be[ing] a world apart"

(P19) and having a different status among the other programs has been described by this interviewed participant:

> *I think they see themselves as separate to some degree and that's facilitated by the separate funding model, different way they've been funded with these cash allowances. Again, we have lots of services that are funded through the separate envelope but it's the culture around how they are funded what they received, the extra, you know, the nice furniture and all that staff. It seems the culture of the team is that they see themselves as different from the rest of the Addictions program (P17).*

Indeed, these differences have been perceived by the team itself, despite being part of the Addictions Program and despite using some of the treatment approaches adapted from the treatment for substance abusing populations. Interviews and participant observations reveal that the Problem Gambling Service considers its practice more autonomous and dissimilar to the rest of the Addiction programs in a number of ways:

> *...because we are the satellite office, we are a little bit... maybe more autonomous in some ways, like it's not that we don't have the same procedures and policies as CAMH, we're part of the CAMH. But I think PG is just a little bit different... (P4).*

The difference in clientele seeking treatment at the Problem Gambling Service, compared to other addictions programs, has also been observed to act as another factor:

> *People, who come through our door, are lot of times very highly functional, a lot of them have really good jobs, highly educated, you know. I think our population is a little bit different... (P4).*

Compared to the Concurrent Disorders Service, the pressure to make changes in the delivery of problem gambling services, particularly in the structure

of the treatment environment, lacked substance and were much delayed. The primary mode of treatment at the Problem Gambling Service had been individual therapy until about two years ago. This allowed clinicians to have greater freedom for using "their models" or philosophies of care:

> *Everybody was doing their own stuff individually. Even though we were running groups, every group was different, everybody was doing their individual differently and even though we always met weekly to discuss cases and worked together, still it was not a lot of teamwork going on (P1).*

The increasing numbers of clients seeking treatment for problem gambling led to, "the decision ... to introduce more groups" (P6). Pressure from management to define treatment more specifically and thereby increase the quality of care also initiated some of the recent changes in the Problem Gambling Service since "everybody doing it individually ... is pretty hard to manage or supervise" (P1). The above quote illustrates that the different institutional environments of problem gambling treatment permitted the use of individual modes of therapy and more variable treatment approaches by clinical personnel. One of the participants summarized the factors related to the experienced pressures as follows:

> *I think that kind of pressure started cascading down on (name) that... 'you guys don't have a program, what is your program'? It was not a definable program rather than a bunch of therapists doing individual therapy. So, I think the number of things, that pressure that was starting to come down to develop something that could be really labelled as... this is our program, this is the treatment people go through (P4).*

The growing emphasis on clinical research, program evaluation, and the use of best practices in CAMH contributed to the decision to move to group treatment for problem gambling. Unlike individual therapy, group therapies are often developed as brief, highly structured therapies that can be better evaluated, and staff can be better supervised and controlled unlike individually provided care. The change towards the group mode of treatment was described as a challenging process: "certainly the switch to the group program was ... very much ... twisting arms to make it happen" (P1). A member of a clinical team also reflected on the process as a difficult one that faced a lot of opposition from clinicians: "there was a lot of resistance to that amongst the therapists, an awful lot. The manager had to work very hard on this" (P4). Organizational inertia, a certain level of uncertainty about the new direction of the program, and differences in staff treatment orientations played an important role: "I think people dragged their feet and there was a lot of not being able to agree on what we should do because, I think, part of that was it wasn't so much clear...what we needed to do was not that obvious" (P4).

Staff reactions to changes in this program are similar to attempts made in other clinics; one of the clinical managers from the Concurrent Disorders Service shared experiences in attempting to make changes in the delivery of services. Perhaps because of uncertainty or "fear of the unknown", clinical staff prefer to use their own personal – and by extension proven - treatment approaches:

I am thinking of changes that we probably are going to make and that's where I think I am getting a little bit of a potential tension with some of the staff because they like to do things the way they like ...they want to keep things... they like the groups, they like the work they do ... (P15).

However, the research participants from the Problem Gambling Service reported that once it became clear that a change towards group programming was inevitable, staff became more involved in the process of restructuring the treatment environment and the change became more of a collective effort: "we did it collectively, we had a few planning days, we explored different options and that's how we ended up with (this)" (P6). Participation in the planning and re-development of the services allowed staff to have greater control over the direction of the changes. Although the result was not an explicit definition of the specific treatment method, the program became more structured with the emphasis on evidence based practices and isomorphic with the organizational environment within CAMH.

In this section, I have presented a case where a broad range of treatment philosophies co-existing in the same program posed a challenge to restructuring and defining the treatment environment of a particular program. The personal and professional preferences for treatment approaches can make the process of obtaining consensus difficult and prolonged. CAMH attempted to implement a harm reduction approach to addiction to homogenize the treatment environment through the training and supervision of the clinical personnel. At the same time, clinicians brought their previous experiences and built upon their expertise. This process of implementing one's own clinical skills and experience along with

specialization of services of individual clinicians will be discussed in more detail in the next section.

6.4 Internal Structuring and Specialization of Services

In this section, I shall explore how internal structuring and specialization of services have contributed to the institutionalization of integrated treatment in the Concurrent Disorders Service and the increasing recognition of comorbidity in the Problem Gambling Service. By illustrating the internal structuring, specialization, and other programmatic changes in both programs, I will demonstrate how individual agency, personal preferences, and professional training helped define the therapeutic orientation of specialized programs that evolved from the core treatment milieu at the Concurrent Disorders Service.

According to Scheid (2004), specialization and intra-organizational diversity is another way to adapt to the various demands of institutional environments and gain legitimacy. The internal structuring and specialization of the Concurrent Disorder Service through the development of new, smaller programs and clinics for specific subpopulations responds to the demand for services from specific subgroups of individuals with concurrent disorders as well as the effect of professionalization and the individual agency of specific employees (Maguire, et al., 2004; Townley, 2002). For example, one of the clinicians was credited for initiating the services leading to creation of the Concurrent Disorders Service: "that was really the brain child of (name)" (P13).

This paralleled the recognition of concurrent disorders as a problem on multiple levels including clinical research, rationalization, and integration in the province, as well as the demand for services:

> *The ARF began to realize that a high percentage of people have mental health issues and so we set up a mental health clinic and initially that was actually a research device. They weren't really doing systematic care for people but they were trying out different interventions and collecting information, doing assessment-oriented stuff for people and then they wanted to set up more formal concurrent disorder service (P19).*

Looking for expertise specific to concurrent disorders, the former Addiction Research Foundation had hired a professional from another organization to formalize the mental health element within its organizational structure : "we started with that - we would offer people groups and the people would have primary therapists - and this was (name)'s model, he had been doing this in (city) actually" (P19). Although the abstinence-oriented treatment of the new leading member of the team was within the spectrum of acceptable goals of the treatment ideology, the research participant (P19) reflected on the fact that this could possibly hamper the functionality of the program and certain level of homogenization of the existing therapeutic environment:

> *We had some differences, (name) and me. One was that he was anti-harm reduction, although I think over time he changed his view about it (after) coming in. I'd been working in a harm reduction way with opiate clients... so, I thought this was just not going to work very well. Actually, I wasn't optimistic about how this would work out but it worked out quite well actually (P19).*

The greater level of eclecticism and creativity in seeking the models to accommodate the needs of the populations considered difficult to serve were part of the evolutionary process of the Concurrent Disorders Service:

> *Now, one of the things is that actually the kinds of groups we were offering weren't really indicated for the most severely mentally ill because they were psycho-dynamically-oriented kind of process groups and ...those were one set of clients we actually deliberately kept out of these groups because we knew that they just had trouble, they couldn't handle the complexity of it. So, what we did is we set up a group for them...the main function was really support and to provide ...kind of a bit of a safe haven every week for these individuals...and we didn't require that they have abstinence goals or anything like that (P19).*

As stated earlier, clinical practitioners often identify themselves with different treatment philosophies and therapeutic schools that they were exposed to during their careers. Adopting harm reduction as an overarching model with a range of treatment goals enabled the programs to keep their clientele, retain various treatment approaches, and to seek new, more legitimized practices. A good example of clinics forming around a certain subpopulation and the professional interests of involved staff within the Concurrent Disorders Service is the Dialectical Behavior Therapy Clinic. It was formed around the evidence-based model of treatment for people with borderline personality disorders, the Eating Disorders Program, and the Anger and Addiction Clinic. After the specialization of services and ability to refer clients who met the criteria for specific problems to these clinics, the last clinic or program was formed: "the final turn was to turn that core clinic of services into a clinic" (Field notes, June 18, 2008) embarking on the Integrative Group Therapy Clinic [IGT]. A staff

member, "very highly well trained beyond a lot" (Field notes, June 18, 2008), was appointed as head of the clinic formed around the services provided to heterogeneous clientele with severe mental health and substance use problems. The process of consolidating existing therapeutic resources into the Integrated Group Therapy clinic is described by this research participant:

> *...given that the CDS seemed to be evolving in both in size and complexity...and there were already some other colleagues who were developing their own clinics, they felt it would be good if the remainder of the therapists who were at that point in a slightly kind of non-specific set of role ... they were doing some group work but they felt it would be kind of better for research, teaching and clinically that this area too becomes consolidated into a clinic...(P15).*

This clinic was built upon the experiences of clinicians and utilized existing resources:

> *...these clinicians were already working in groups with these patients. So, it was more .... to see how we could work with what's been already there and just tighten it kind of administratively to that it could really run as a clinic.....I felt that that was a strength we could build upon as a clinic and we decided to call it the Integrative Group Therapy Clinic and really to make that a strength that we are not that specific that we kind of treat one kind of a patient with one kind of approach, but that we apply integrative techniques, that we certainly rely on interpersonal principles of how groups interact (P10).*

In addition to the normative and mimetic isomorphic processes, the demand for the services from different client populations contributed to the specialization of the Concurrent Disorders Service:

> *The final thing that happened in concurrent disorders developmentally was we thought we should focus on some special populations. Not because of some fanciful idea ... because they were really present in our system and they were actually populations that people didn't want to work with, that end up with us anyway. Like personality disorders uh... borderline. So, (name) and (name) were interested in this new thing - dialectic behavior therapy and we knew that addictions and personality disorders kind of go together and particularly with borderline clients (P19).*

A staff member who was working at the former Addiction Research Foundation and became instrumental in creating a portfolio for a Dialectical Behavior Therapy Clinic prior to the merger recalled an early experience working with clients with mental health problems:

> *There was suddenly a great excitement to integrate a psychologist – let's refer her really difficult challenging clients that we don't know how to deal with. Within about a month I was pretty overwhelmed and almost ready to quit my job because suddenly I had got like a large case load who really fulfilled the criteria of borderline personality disorder and I realized I wasn't able to do it on my own...this was not gonna work and at that point I sort of turned to literature to figure out* what *else could be done...what could we do differently... and, I came across dialectical behavioral therapy and actually to be honest when I read the book I just thought it made so much sense (P9).*

The Dialectical Behavior Therapy clinic strongly adheres to the US-based treatment model developed by Linehan (1993), which has since been supported by clinical research and treatment evaluations. Afterwards, the model was adapted to substance using clientele, a move that was very suitable for the Concurrent Disorder Service that operated under the roof of the Addictions Program:

> *I got interested in trying to apply this to our addicted patients because at that time there was no literature, even in the DBT, on addicted population. I contacted Linehan and found out she was actually in the process of trying to apply it to substance addicted clients (P9).*

The clinicians who expressed an interest in adopting the new therapy were supported because the approach has been: "an interesting case of where... sort of the evidence seems to take you on this direction and you seem to have an advantage over some of the other approaches. So we... we got them trained" (P19). As in other programs, initially the idea to use the Dialectical Behaviour Therapy as a method was not met with a lot of interest:

> *I got additional training as did one of my colleagues. At that time...there was not a lot of interest from the staff to get involved in doing this work. I mean very little ...I remember having twisted one of my colleague's arms to get involved in it, he was not so interested in it... I couldn't get people to do it. Mostly because people didn't want to work with clients who were substance abusing, self-harming who were just more chaotic... (P9).*

However, once the program became an established service with its own clinical research, training, and consultations it became the program to model other services in the community after:

> *I think what ended up happening was just certain momentum and energy and stuff...we kind of over the next few years managed to attract more people. So, some of the early people that'd got involved left... some people were sort of assigned to it but weren't interested... but we ended up getting therapists who actually were interested and we are now at the point where...it's obviously grown and not only it is their (therapists) interest but there is interest from outside of the community ...people actually want to be here and want to do work here... (P9).*

Another research participant reflected on the success of the Integrative Group Therapy clinic that has also met with high credibility and acts as an active element in shaping the institutional environment of concurrent disorders:

> *So, they [therapeutic groups for CD clients] actually became quite a success and we started with one group and number two, three... groups. People in the community got interested in them, wanted to come and watch us do it and people have been doing them now kind of around. They got their variations on them. We ran our groups as open ended groups. Some people wanted to run them as like, you know, 12-week groups or 16-week groups or whatever with kind of more of a structured format to them. But—so there's been a kind of a growth...a growth on these CD groups...you know, in the system actually and they might have happened anyway but the fact that we were doing them here I think was really a great sponsor of that...(P19).*

The data illustrates that changes of institutional environment and attempts to gain legitimacy through association with established treatment approaches has been a contributing factor in the development of integrated care at the Concurrent Disorders Service. However, the inter-relationship between individual agency, the professional orientation of staff members, and the process of specialization of the provided care has to account for factors that that have contributed to institutionalization of services:

> *So, within concurrents we've got like eating disorders focus ...we had anger and addiction focus and we've got borderline personality focus and it really is organized around a clinic head, PhD researcher/ clinician and we organize staff around them and they really set the direction of the clinic, around their research, their interests, their research studies and really it's ...it's a niche and a need within a field (P17).*

One negative effect of this specialization is illustrated by the following; one of the Concurrent Disorders Service's small clinics — the Anger and Addiction Program — has been practically closed after the clinic head, a specialist in the area, left the organization. The challenge of hiring a new professional and the potential for directional change in that small program is evident from the interview conducted with this research participant:

> *An example right now is that we had the third clinic. It was the Anger and Addiction. So, since (name) is gone we're not able to fill that position because it's very hard to find somebody who has an expertise in anger and addiction and so ... the position is sitting vacant...and you know the intention is to find somebody with that specialty but it is very difficult so the decision has to be, you know, do we continue on that path or do we bring somebody else with another specialization or interest and form a clinic around them (P17).*

The next quote strengthens the argument of my research participant above (P17), confirming that professional orientation and specialization of clinical personnel is an important factor to consider when hiring new staff members on the basis of their suitability to institutionalized clinical practices:

> *At CAMH, because we are a leader in mental health and addiction, we have a lot of really good people. We cultivate them and we build leadership within...believe me I have advertised tons of positions and I know the calibre of people that are available to us and lot of them are external to the organization but a lot of them are right here under my own roof. We have really superior people that we need to cultivate who have got great clinical experience and have a leadership potential (P13).*

Established organizations take great care in selecting new professionals who are then expected to conform to their institutionalized practices, unless of course the organization is seeking a radical change in its structure or orientation because of

institutional environment pressures (DiMaggio & Powell, 1983/1991; Scheid, 1994; 2004). The data indicate that social actors with their interests in particular institutional arrangements are not passive bystanders subject to regulative, normative, and cognitive processes but are able to envision new processes and then diffuse or translate them into new institutions (Garud, Hardy, & Maguire, 2007; Maguire, et al., 2004; Townley, 2002; Zilber, 2007).

Compared to the Concurrent Disorders Service, specialization at the Problem Gambling Service has not focused on defining a specific method of treatment but rather focuses on diverse populations (women, youth, elderly) and expanding into a multilingual service for ethnic populations (CAMH Annual Report to the Community, 2008-2009). This has been another highly endorsed agenda:

> *We added an ethno-cultural specialist in 2000 and that, I think, made a huge difference in terms of our accessibility to ethno-cultural populations. Gradually, we started a collaboration with COSTI immigrant services in 2000 and for that reason we got even further in terms of understanding of the needs of ethno-cultural populations, doing outreach to ethno-cultural populations and then a training of services providers...ethno specific agencies to provide treatment (P1).*

According to this staff member, the specialization of services can increase the odds of their survival, particularly in a changing institutional environment; relevant changes included the recent provincial restructuration of health care governance: "Well, you know, with LHINs coming in we need to ... the suggestion or at least assumption is... that we need to be specialized in order to

be secure in terms of our funding, and to be unique" (Field notes, November 18, 2008).

Studies on the co-occurrence of gambling problems, substance use, and mental health problems have documented the high overlap of comorbidity discussed in detail above. Populations with gambling problems and other mental health and substance use problems have been increasingly recognized as those that require simultaneous and integrated treatment. At the same time, addressing issues of comorbidity among problem gamblers have found support through additional funding: "the connection with concurrent disorders is probably one of the reasons for which we have the most resources. So, yeah, we have been looking at programs ... (such as) concurrent disorders" (P1). Accordingly, the Problem Gambling Service hired an external psychiatrist for PGS staff to consult on cases where the co-occurrence of problem gambling with mental health or substance use problems impedes positive treatment outcomes. The psychiatrist would conduct a "one shot assessment" (Field notes, November, 26, 2007) of a client; however, if the client was in need of psychiatric treatment, treatment had to be provided outside of the Problem Gambling Service, either at CAMH or in the community. As one of the clinicians noted, referral into other programs within CAMH services can be very difficult:

> *There is big black holes I find in that whole referral process and what happens... I find that referring a client from here to another service at CAMH can be a huge headache and sometimes impossible because of the wait lists and... I don't think problem gambling is even recognized ...was only recently recognized as a possible concurrent disorder (P4).*

The above quotation illustrates that CAMH, although mandated to provide both mental health and addiction services, has been experiencing very similar problems as mental health and addiction systems criticized for being disconnected from each other and difficult to access. I will elaborate in a later section on the way CAMH has attempted to address this challenge by developing the Concurrent Disorders Capacity Building Team as part of the Concurrent Disorders Service.

In this section, I demonstrated how professional interests and the specialization of particular individuals working in the programs have contributed to the institutionalization of integrated treatment. These findings imply that clinical practitioners and program managers are not passive carriers of institutionalized practices; they are present in the process of interpretation and when enacting institutional meanings; their actions shape their immediate environment as well as their broader institutional environment.

6.5 Technical Consideration of Treatment Efficiency versus Client-centered Care

In this section, I present how the institutionalization of integrated treatment for concurrent disorders has been affected by the pressures on the programs to conform to the technical efficiency of treatment for a population with concurrent disorders. I will present my findings and explore how empirically-based treatment for concurrent disorders gained considerably greater legitimacy within CAMH

than treatment dependent on the professional prerogative (discretion) of clinical practitioners. The input from clients with concurrent disorders and from their family members demonstrates the need for individually tailored, often long-term, and comprehensive treatment for populations with concurrent disorders. Before concluding this section, I discuss the various means whereby the institutionalization of integration for concurrent disorders treatment exists at CAMH.

Rising health care costs have increased scrutiny on the performance of health care providers, particularly mental health and substance use services that are much more qualitative in nature (Hasenfeld, 1992a; Scheid & Greenley, 1997). The specifics of human service organizations' institutional rather than technical environments make evaluating organizational performance a challenging task. The complexity of human conditions, fewer technically-driven treatment technologies, and methodological problems derived from loosely coupled organizational structures are among the most recognized differences in the evaluation of treatment outcomes (Hasenfeld, 1992a; Scott & Shortell, 1988 in D'Aunno, 1992). Also, mental health services, functioning in highly institutionalized sectors, are subject to such structural controls as accreditation, certification, and licensing (Schlessinger & Gray, 1999; Scott & Meyer, 1991). Mental health and addiction services have been increasingly pressured to demonstrate measurable outcomes and particularly cost-containment policies. With mental health services in the United States, more technically driven models of treatment efficiency have been adopted that do not acknowledge these unique

characteristics (Schlessinger & Gray, 1999; Scheid, 2004). Likewise, the treatment programs under my study, as part of a larger organization in a health care system, have been under increased pressure to become more cost-efficient:

> *I don't certainly feel that my higher-ups have set bureaucratic and administrative [constraints]... on me that would compromise clinical care. Have we tightened up over the last ten years and have we been forced to become more efficient? Do we track workload a lot more, do we make data-driven decisions? Absolutely, but everyone has to become more efficient in health care, it is 50% of the provincial budget, like, we have to be more efficient. So, I have not seen that up until now but I think we are entering a new era with the regionalization of the province and the LHIN environment and I think it is quite possible that things will change for us in terms of you know our accountability. And how we as a hospital are managed (P13).*

The financial constraints had become a reality when CAMH submitted its first deficit budget for 2008-09 and 2009-10 to the Toronto Central LHIN (Beyond the Boardroom: online update on CAMH's two years budget), http://insite.camh.net, retrieved, July 22, 2009). An increased emphasis on performance-based outcomes became even more obvious during the rationalization of health care that will affect CAMH in the near future:

> *Going forward though, apparently it's gonna be a very difficult year. You know, around the organization there were people laid-off. So, we're lucky in the [Addictions] program that we didn't have to do that, but going forward we're not sure how much we'll shave off from our budget. We'll have to shave off a fair amount of money, apparently (P17).*

The Concurrent Disorders Service and the Problem Gambling Service are part of an institutional environment where legitimacy is derived from conformity to normative beliefs and societal preferences. However, demonstrated technical

competence and successful and measurable client outcomes have become requirements for further funding and support. Accordingly, the endorsement of evidence-based practices has been sought to increase service providers' legitimacy and maintain stability in changing institutional environments:

> *...one of the major focuses that was in the ARF ...we kind of carry that legacy on... is that there is a real emphasis on what we do is evidence-based and it is evidence-informed. Uhmm we really need to have some dedicated resources to ensure that we know what the literature is saying and that our resources and products are informed by that (P10).*

The services for treatment of problem gamblers, including training and development for professionals has been enhanced by research positions in both the Problem Gambling Service and the Problem Gambling Project to keep the programs informed by the newest findings in professional literature. However, a member of upper management noted that having a research position for this purpose as part of the organizational structure has been more of a privilege for a well funded problem gambling service rather than standard across the services at CAMH.

Clinical Autonomy (Professional Prerogative) versus Treatment Efficiency

Increased rationalization and technical consideration of efficiency of care diminish the autonomy of clinicians and the role of professional prerogative in clinical practice (Scheid, 2004; Scheid & Greenley, 1997). Incompatibility between the wider normative standards determined by professionally generated norms and technically driven cost-efficiency of treatment were observed in both

the Integrative Group Therapy clinic and the Dialectical Behavior Therapy Clinic. For example, the leading clinician, influential in shaping early the CDS, was described as someone who honoured the individual input of each clinician, rather than emphasizing a highly structured treatment environment:

> *...To give him credit, he really trusted the therapists. He actually thought that the most important element in the helping process was the relationship and so he wanted good therapists who could, you know, do the best they could without actually scripting too much in these groups (P19).*

After the specialization of the Concurrent Disorders Service described in the previous section, when the "core" of clinical services turned into the Integrative Group Therapy clinic, the legacy of this approach has been carried on, mainly due to the similar professional orientation of the clinical staff:

> *...I have left a lot of autonomy up to the clinicians to work the way they do because to me, simply they were doing good work with their approach and with their styles, so to me it was just seeing if I can help to enrich their approach (P15).*

However, unlike the legitimized treatment model used in the Dialectical Behavior Therapy clinic, the psycho-dynamically oriented interpersonal therapy provided in the Integrative Group Therapy clinic has not become a mainstream model for clinical practice with substance abusing populations. It has been overshadowed by behavioural models of relapse preventions, motivational enhancement therapy, and other more structured and empirically based treatment models. At the same time, the emphasis is on the therapist, and particularly the interpersonal relationship between the client and therapist, as a defining factor of

the helping process, stands in contrast with the standardization and technical criteria of developed interventions:

> *The therapeutic relationship is much more important than any method that you work in. And, so these common factors that actually make people think and having a good [relationship]...like, "these are good people. I trust them, they understand me...I feel a strong connection to them". That's much more important than, they've got this method and I don't care if they're nice or not (P19).*

Clinical autonomy allows for better tailoring of services to individual needs of clients with complex needs. This complexity is another factor that makes the evaluation of integrated treatment for concurrent disorders challenging to ensure long-term support in many areas of client life:

> *So, what we did was, we really worked more on the idea that for these individuals... yes, you needed to be able at times to provide intensive services. The other thing is you need to support them over the long term (P19).*

Another participant also emphasized the specific role of the IGT clinic for the clientele that is difficult to serve by other service providers:

> *...[our] research and clinical interest is to keep patients in long-term treatment because they need it and I think they relapse quickly if they are discharged and these are complex patients that are not often easily absorbed by kind of typical community agencies (P15).*

Long-term treatment, however, is not easily accepted because of its potential to drain resources from programs and it is not compatible with increasingly popular therapies that are more structured and brief. On March 18, 2008 after participating in a meeting at the Problem Gambling Service, I spoke to a staff member about the presented treatment outcomes. In our discussion, a group

therapy that was less structured and dealt with clients' "deeper" issues rather than coping skills was something that the staff member felt that the organization would "have to look at more closely". In addition, the staff member felt that they would have to find out why a facilitating therapist "keeps them (clients) there for so long" and "something has to be done with it".

Interestingly, one of the models that the Problem Gambling Service adopted in the delivery of its practice is the Pathways model (Blaszczynszky & Nower, 2002) claiming that there are three subgroups of problem gamblers whose underlying problems are related to their emotional, or psychiatric problems. Subpopulations belonging to pathway 2 and 3 often have complex substance use, mental health, and gambling problems manifested in multiple maladaptive behaviors that need to be addressed by providing comprehensive treatment services for underlying vulnerabilities and problem gambling (Blaszczynszky & Nower, 2002).

Similar challenges have been experienced at the Dialectical Behavior Therapy clinic which serves clients with borderline personality disorder who often experience concurrent substance abuse and self-harming problems: "I think other challenges are just related to the fact that this is a clientele that actually is more severe, is higher risk, utilizes more health care services, is more resource intensive..." (P9). As a result, many hospitals do not want to involve themselves in such resource-draining treatment, which further exacerbates the problem of treatment accessibility for this population; the clinic has been flooded with demands for treatment which at times result in freezing their waiting list. My field

notes on interviews conducted with the clinicians reveal that these factors - high demand for services, a very long wait list, and insufficient resources - were part of the decision not to provide "the whole package" but to reduce interventions and provide mostly skill-oriented groups to accommodate more clients:

> *...I don't want to use the term "light" because I don't think that is what it is ...but it is more of ...it's reduced, less intensive intervention and the idea is that it's designed as an adjunct to standard treatment. It is not meant to be offered on its own because usually these clients need more than a group skills intervention. Uh... but it just recognizes the limitations of our program not to be able to offer comprehensive package to everybody... (P9).*

Some of the clients and family members I interviewed experienced this insufficient capacity of some of the programs. Although some clients did not have problems accessing the treatment, I received phone calls from clients who wanted to participate in my study in the hopes that it would facilitate their entrance into a program.

Even in the case of evidence-based treatment at the Dialectic Behavioral Therapy clinic, the lack of resources or emphasis on technically driven treatment efficiency does not permit the delivery of all features of the model. The following quotation illustrates the point Scheid (2004) made in her study that mental health professionals tend to be guided by professional standards of care rather than numbers:

> *...we haven't managed to get fully funded....uhm, so for example... it is part of DBT to offer 24/7 coverage. The way it's typically done in other programs is that the primary therapists would be on call for their own clients. We don't ...we have received funding to have one therapist on call until 8 o'clock at night and then on the weekends someone is on call from eight in the morning till eight at night. Outside of those hours after eight o'clock at night uhmm all the calls are handled by myself and two psychiatrists, so there is not compensation for it (P9).*

The professionally driven consideration of what is perceived as a high quality of treatment is expressed in this quote as an example of professionals going "above and beyond" their responsibilities:

> *...we deliberated about it as ....we have been doing that for a long time and there is a question about, I guess,..."why are we doing this"? Because there is no compensation, we carry pagers after hours with no compensation uh... I think that the bottom line is that everybody believes that it is helpful so that's why it is being done (P9).*

In the quest for successful and meaningful cost-efficient treatment services, the interviewed clinical staff felt that the management cared more for the "numbers" and act[ed] as "bean counters" (Field notes, June 24; 2008) rather than taking into account the severity and chronic nature of client conditions. However, a client interviewed for this study stands in contrast to these opinions. This client has found the treatment for his concurrent anxiety, depression, and alcohol abuse at the Concurrent Disorders Service to be "a Godsend" and acknowledged that his primary therapist has managed to support him in his recovery, which has been a long and continuing journey.

This client's story, filled with failed attempts at treatment, is a strong testimony for the ineffectual, disjointed, and inadequate services he had

experienced in the past when dealing with his concurrent conditions. The willingness to participate and tell his "story" in the interview regardless of his social anxiety was remarkable. This client felt that the program and the therapist at one of the Concurrent Disorders Service clinics provided him with the much needed assistance he had lacked before and that the safety net he could access was a very positive and valuable resource:

> *One day...I was walking to CAMH at the east end and I was walking and I had a panic attack and I just sat down for two hours and I could not move and I felt bad about the whole thing. And...I did not go back and I went home again and it bothered me for the longest time...(P21).*

The feelings of embarrassment and inadequacy for failing to attend the individual appointment with his therapist prevented him from coming back and continuing in his treatment, until regular telephone contact and reassurance from his therapist encouraged him to continue seeking support. The therapist reminded him that these "failures and relapses" were simply part of his journey:

> *A few years ago I had major, major situations and (name of therapist) supported me, like writing letters for me and things like that and a doctor as well. That's the greatest asset right there ...to know that someone is there, that is the greatest asset... because I was wondering why am I like this, why is my brain like this and not....you know... and to have long term (support)...(long pause)...it was great because maybe I (will) never ever not be a client ... (P21).*

The need for ongoing support, a part of the client's acceptance of his or her complex problems, and flexibility of treatment goals have been particularly important for serving the clientele who have minimal options for receiving care in other general treatment settings. This client's therapist however mentioned that

providing clients with long-term, comprehensive support has been a challenging task in the environment driven by technically-driven efficiency.

The remaining challenge for finding strongly supported evidence-based care for concurrent disorders is the heterogeneity of the population with concurrent disorders: "When you say, 'What's the evidence base for dealing with alcohol plus depression?' There's very little, by comparison, and so some of that work still needs to be done (P19). Often, integrative care is based on the extrapolation of findings from both domains – alcohol or depression treatment, which allows one to "approximate around what might work" (P19) rather than having more specific findings on co-occurring depression and alcohol problems. Consequently, many studies that have attempted to develop evidence-based practices focused on just one problem and clinical research "deliberately excluded people who have complexity because you know, depression research won't take alcoholics, alcohol research won't take people who are depressed. Psychosis research won't take people who are cannabis users" (P19).

Institutionalization of Integrated Treatment through Capacity Building

The most satisfying level of integration of services for concurrent disorders in CAMH has been achieved by the Concurrent Disorders Service and its clinics. It has been perceived as a "successful prototype" of integrated practices under the same roof and this has been acknowledged by clients, family members, and professionals working for CAMH, including higher management:

> *I think CDS itself has done a pretty good job, every physician is a CD physician, every clinician is designated that way, they treat clients who have mood and psychotic disorders and substance use issues, so and I think they were set up to do that. We wouldn't even hire staff for that service if they said they did not want to treat that population because it's in the job description. So, It's not really an issue for that service, it is an issue for other services (P13).*

The specialization of the services and the proficiency of the staff is a result of the past ten years of training and development of the services; this is described as a demanding and continuous process of service improvement:

> *I think that staff in that service has had a lot of training in both areas and it is a hard field and there is a lot of information you have to be trained in, it is highly, highly specialized the amount of scientific information that is coming out in neurology and psychiatry every year. There is a huge set of findings that people need to be up-to-date on as well as addictions too. So, I think that group of staff is in an area where (there) is a group training, there is good support, good supervision, there is psychiatry working side by side with addictions therapists. I think those clients get really good service and I think if those clients decompensate and they are admitted to the hospital to the psychiatric bed, I think there is a good opportunity for mental health clinicians to get consultation from a CD clinician to inform the client's care (P13).*

The challenges of integrating mental health and substance use care remain extensive among programs at CAMH. One family member characterized the service as the "cream of the crop" of treatment services, but one that has its own life, often isolated from other programs (Field notes, March 20, 2008). To overcome this isolation and work through ideological, administrative, and bureaucratic separation of programs that deal with concurrent disorders within CAMH, the Concurrent Disorders Service has taken an initiative to build a

consulting team for concurrent disorders in other programs. There were different views expressed, however, regarding the success of such a team in building concurrent disorders capacity across CAMH:

> *So how do you take that expertise and leverage it that every mental health and addiction program service has a minimal amount of capacity to deal with co-occurrent disorders? Like, I meant if the problem is that broad then setting up little boutiques here and there is not going to be effective from the public health perspective and that's their challenge so how do you get the schizophrenia program to have CD capacity, how do you get mood disorder programs where a huge percentage of clients have substance abuse issues? How do you leverage that? And I think you do that by capacity building (P13).*

While the Concurrent Disorders Capacity Building Team has thus far been praised for successful cooperation with the Emergency Unit and for providing individual consultations across CAMH, this participant remained skeptical of the Team's capacity to increase the level of integrated treatment for concurrent disorders across the whole Centre:

> *I think the whole Consult Liaison model is difficult. You know it's been many years now already that we've been merging and...that strategic plan has been implemented (not only) across the organization but across the whole staff...like the uptake for staff around the organization has been slow. You know we've got a very small team and to have them charged with training people around the organization...the numbers don't match, right? (P17).*

Both quotations illustrate that the integration of services within the CAMH remains a daunting task, just as it has been across both systems, and the problems experienced at CAMH often mirror the problems and obstacles present in its wider organizational context.

6.6 Concluding Remarks

In this chapter, I presented findings that focused upon treatment environments of two programs shaping and being shaped by the changes in their institutional environment. I demonstrated how the legitimacy of integration of treatment for concurrent disorders was augmented after the merger of four specialty hospitals and established as the Centre for Addiction and Mental Health (CAMH). CAMH has become an important advocate for the integration concept. This was presented through the analysis of new organizational texts, language, and symbols that were created and diffused across the multiple levels of organizational and individual policy.

The main contribution of this chapter is the findings presented as micro-level foundations of the institutionalization of integrated practices. These findings and their interpretation as they interact with actions, meanings, and social actors including program planners, clinicians, researchers and policy-makers, contribute to a better understanding of organizational processes. These processes were enacted through development and dissemination of new texts, the adoption of and adaptation to the new treatment ideology, and contributions to internal structuring and specialization of provided treatment. These micro- level concepts have brought a new dimension into neo-institutional analytical frameworks that had previously been preoccupied with macro level analyses of organizational adaptation to their institutional environments.

Chapter 7:

Discussion

Introduction

In the previous two chapters, I presented the findings from a case study of two treatment programs designed to explore the institutionalization of integrated treatment for concurrent disorders. In this chapter, I discuss some of the key themes, interpreted within the framework of neo-institutional theory, and the literature related to these findings. Several important insights came to light regarding the institutionalization process of integrated treatment and the organizational characteristics of both programs.

As a rationalized myth, integration can be used to manage and monitor conflicts of organizational change while still demanding further study of treatment options for concurrent disorders. "Translation" of integration concepts can facilitate institutionalization in a uniquely Canadian context, while still requiring constant attention to the terms and vocabulary incorporated into the services at CAMH. Problem gambling treatment in particular is still attempting to clarify its service mandates and approaches.

The implementation of new institutionalized practices and models is a sensitive process that involves not just structural and organizational changes but also adjustments in the personal beliefs of professionals and other participants. CAMH was able to incorporate these concepts into an effective merger in 1998 and it has been fairly successful in representing integration because of its

existence. More work is still required before the comprehensive integration of treatment for concurrent disorders can be considered a success story.

The review of the institutional environment of mental health, substance use and problem gambling services in Ontario provided an important context for the analyses of both programs, along with their historical evolutionary development. By examining the systems in which the treatment programs have been embedded, a more comprehensive interpretation of the institutionalization of integrated treatment as a non-linear, multifaceted process has been identified. The programs, differing in their current mandates but similar enough in other organizational respects, were examined to explore how they responded to the pressures of and their attempts to shape their institutional environment.

The review of relevant literature clearly shows that integrated treatment for concurrent disorders has become part of the political rhetoric for optimizing quality of care for this population in the United States and Canada over the last twenty years (Health Canada, 2001; MoHLTC, 2009; Minkoff, 1998; SAMHSA, 2002). The larger institutional environment of the American mental health and addiction systems, associated with greater research capacities, has been particularly instrumental in increasing awareness of the needs of a population with concurrent disorders.

7.1 The Rationale for Integration

Findings from research on this phenomenon report a high overlap between mental health and addiction problems, a conclusion supported by American and Canadian studies over the last twenty years (Drake & Mueser, 2000; Health Canada, 2001; Kessler, et al., 1996; Minkoff, 2001; Mueser, et al., 2003; Rieger et al., 1990; Ross, 1995; Ross, Lin, & Cunningham, 1998; SAMHSA, 2002). These support the need to develop and implement integrated practices for this population. By approaching the high prevalence of concurrent disorders throughout the system of care as the "expectation rather than an exception" metaphor (Minkoff, 1998; 2001; 2005), it has become the rationalized myth for the institutionalization of integrated treatment for concurrent disorders by policy makers and service planners in both Ontario systems.

This rationale has, however, recently come under scrutiny after calls for a more cautionary stance towards data reporting the prevalence of concurrent disorders in population and clinical samples. A recent Canadian study (Rush, et al., 2008c) of the prevalence of co-occurring substance use and mental disorders at the population level reports a lower range of comorbidity than previous Canadian and international studies. Recent clinical studies in Canada also reported lower figures than studies conducted in the 1980s and 1990s (Ross, 1995; Ross, Glaser, & Germanson, 1988). Still, the data applicable to the mental health system highlight the need to focus on specific subpopulations with higher

severity levels of concurrent mental health and addiction problems (Rush & Koegl, 2008).

Rush, et al. (2008c)[25] also recommend that the addiction treatment sector should expect the co-occurrence of mental health problems, particularly among certain subpopulations such as co-occurring substance use and mood and anxiety problems. The discrepancies in the data could be attributed to several methodological factors, such as the development of new diagnostic criteria, assessment tools, or the exclusion of several mental disorders or populations from the survey rather than incorrect reporting. Cautious interpretation and generalization of collected data are vital to both the studies that report high prevalence of concurrent disorders as well as those studies that challenge it. This particular study is not designed to provide detailed information on the prevalence of concurrent disorders in populations and clinical samples. Rather, it demonstrates how reported data can become an integral part of the rationale for institutionalization of new practices or the de-institutionalization of the established ones, and thus how the data can balance and fulfill conflicting mandates.

Although the high overlap between mental health and addiction problems has been accepted as valid support for treatment integration on all levels, treatment interventions, programs, organizations and systems, changes observed in both systems as a result have been perceived as limited. From the historical perspective, the bifurcation of the mental health and addiction systems led to a systematic disconnect between the two. Concurrent disorders demand a

[25] Any lifetime or current mental disorder was 81% and 70%, respectively; lifetime and current mood disorders were 62 percent and 43 percent respectively; anxiety disorders were 51 percent and 34 percent respectively.

reassessment of these disconnected systems and argue that a closer connection – if not integration – is needed to manage the affected populations.

The second argument that contributes to the institutionalization of integrated treatment for concurrent disorders claims that integrated practices are superior to traditional, non-integrated treatment. Although the integration of mental health and addiction services and systems has been perceived as a panacea to problems of concurrent disorders, the evidence is not conclusive on this point (DiNitto, Webb, & Rubin, 2002). There is, in fact, a lack of studies on this issue, particularly with regard to the integration of systems and organizations. The available evidence on the effectiveness of integrated treatment identifies favorable outcomes for clinical interventions by using specific treatment models for specific subpopulations (Flynn & Brown, 2008). It has been emphasized that other factors such as age, socioeconomic conditions, physical health, and treatment history have to be considered when developing and testing interventions and services for concurrent disorders (Alverson, Alverson, & Drake, 2001; Chen, Barnett, Sempel & Timko, 2006; Flynn & Brown, 2008).

The strongest evidence of the superiority of integrated treatment has been provided by Mueser, et al. (2003) and Drake, et al. (2004) for integrated dual-disorder[26] community treatment for clients with severe mental health and substance use problems. Linehan, Dimeff, Reynolds, Comtois, Shaw-Welch, Heagerty, et al. (2002) have also provided promising results for integrated treatment of borderline personality disorder when occurring with substance use

[26] This group of professionals associated with the 'Dartmouth School' uses the term "dual diagnosis".

disorders. Positive outcomes were also present in treatments that addressed co-occurring substance use and PTSD (Najavits, 2002). Clinical research from the "Dartmouth School" emphasizes that increased effectiveness can only be achieved if long-term treatment is provided (Flynn & Brown, 2008; Mueser, et al., 2003; Sacks, Chandler, & Gonzales, 2008). This statement is in contrast to the current focus on cost efficiencies of time-limited treatment as a guiding principle for the provision of care.

The main challenges, therefore, in evaluating treatment for concurrent disorders are the heterogeneity of the population, widely differing severity levels of individuals with these conditions, and the diversity of settings, treatment philosophies, and approaches. Nevertheless, integrated treatment has become a "seemingly obvious, and desirable alternative to the single-disorder [addiction] services for those showing multiple disorders" (Flynn & Brown, 2008, p. 39-40). I argue that although the evidence supporting integrated treatment refers to specific subpopulations and treatment interventions, it has served as a rationalized myth in discourse on integration activities at both the policy and organizational levels. In this regard,"integration" connotes an uncontested positive approach to presumed issues surrounding the treatment of concurrent disorders.

Another argument supporting integration has been the emphasis on providing cost-effective care for concurrent disorders. This argument has been adopted from the broader institutional environment of the general health care system (Schlessinger & Gray, 1999). The structural changes of the health care

system in the United States, particularly the increased control of service delivery through managed care, resulted in the comodification of mental health and addiction treatment (Durkin, 2002; Lemak & Alexander, 2001; Scheid, 2004; Scott, Ruef, Mendel, & Caroner, 2000). In Canada, the existence of a national health care system has prevented such drastic shifts in the delivery of mental health and addiction services (Benoit, 2004). A certain level of mimesis has, however, been evident: the conservative agendas of US governments are mirrored by their Canadian counterparts during periods of politically-induced trends toward greater centralization and homogeneity to promote cost-effectiveness. I identified two instances of mimetic isomorphism between the Canadian mental health and addiction environment and the American mental health and addiction systems. The first of these are the changes in Canadian drug policy as a response to the Reagan administration's "War on Drugs" in the 1980s. The second is the increased emphasis on the rationalization of mental health and addiction systems after subsequent cuts in public spending at the beginning of the 1990s (Horgan, Reif, Ritter, & Lee, 2001; Wells, et al., 2005). The consequences of this rationalization were different in each country: the American mental health and addiction systems has since become heavily influenced by the emergence of managed care, while the restructuration of our health care system in the 1990s led to mergers and hospital closures by the provincial conservative government. Both managed care and rationalization were supported by the political agenda to decrease duplication of services and thus provide better, more effective health care services (HSRC, 2000).

"Translating" Changes in Mental Health and Addiction Systems

The theory that Canada's mental health and addiction systems developed by utilizing American precedents does not sufficiently explain some of the changes experienced on a macro-level. The deinstitutionalization of psychiatric care in both countries exemplifies this issue. I interpret the distinctive features of the deinstitutionalization of psychiatric care in Canada (discussed in Chapter 5) through the concept of "translation" (Czarniawska & Joerges, 1996). This concept includes the use of new ideas to facilitate the institutionalization in a non-linear, multifaceted process energized by participating individuals. Accordingly, the models in the Canadian mental health and addiction systems relate to the American systems as translational organizational change rather than the mimetic isomorphism described by DiMaggio and Powell (1983/1991).

A supporting example of my interpretation of the translational process instead of mimesis are differences in deinstitutionalization of psychiatric care. The policy proposed by the Canadian Association for Mental Health of "medically integrating" psychiatric patients in Canada into communities by placing them in the psychiatric wards of general hospitals (More for the Mind, 1963) differed from the American model of deinstitutionalization that released psychiatric clients directly into the care of community mental health centers. The translation model interprets the adoption of this policy in Canada through the active contributions by participants of the "translation" of ideas and concepts. Individuals who helped adopt organizational models were at the same time adapting them to a

specifically Canadian context. Such individual actors, called "editors", "edit" and mediate success stories circulating among organizations, systems, and different states. This role is vital to the dissemination of ideas in different contexts (Sahlin – Andersson, 1996).

The concept of "translation" is also applied to changes in the Canadian drug policy which, although engaged in mimesis with the American model, has since drifted away from the moral-disease model of addiction towards more liberal and pragmatic solutions. The harm reduction approach using the "Four Pillar" model (MacPherson, 2001) provides a specific example of another stream of drug policy in Canada. I have identified several "editors" in the institutionalization of integrated treatment in this study; these researchers, service planners, and clinical professionals functioned both inside and outside of the organizational structures of CAMH.

The Institutional Environment of Concurrent Disorders in Ontario

The review of national and provincial policy documents revealed that institutional processes in the organization of treatment for people with concurrent disorders were set in motion by different economic and social changes in Canada and Ontario. During the 1980s, individuals with 'dual diagnosis' were acknowledged as a vulnerable subpopulation that would benefit from better community mental health services (The Graham report, 1988). However, no specific measures were proposed or undertaken to improve the inadequate services provided to this subpopulation at the time. Conflicting treatment

ideologies in mental health and addiction services led to the exclusion of clients' treatment in one or the other system (or both) and further exacerbated their problems (Canadian Mental Health Association the Ontario Division, 1997; Health Canada, 2001). The terminology used in the Graham report – dual diagnosis – indicates the low profile of the problem in the Ontario mental health system because it functioned as a vague concept that services were not prompted to clarify. More specific terminology that made a distinction between dual diagnosis[27] and concurrent disorders[28] only became part of the integrated treatment discourse nearly a decade later.

I argue that this eventual clarification of terminology concurs with neo-institutional concepts of institutionalization through the development and specialization of organizational language. The former Addiction Research Foundation first used the term "concurrent disorders" in its provincial needs assessment among mental health and addiction service providers (Melinyshyn, et al., 1996). The Addiction Research Foundation also developed a small concurrent disorders program prior to its amalgamation into CAMH. These activities have helped raise awareness of the importance of concurrent disorders among clinical practitioners. In its report on concurrent disorders, the Canadian Mental Health Association, the Ontario Division also clearly outlined the differences between the two terms and demanded that more attention be paid to streamline assessment and treatment of co-occurring mental health and addiction problems (CMHA, 1997). Concurrent disorders then became a

[27] Dual diagnosis: a combination of emotional, psychiatric, and development problems.
[28] Concurrent disorders: a combination of mental health problems with the abuse of alcohol or other psychoactive drugs.

problem with high importance discussed among policy planners and service providers.

The development and adoption of new, more specific language has two implications for the institutionalization of integrated treatment: first, organizational language is an important factor in depicting and communicating actions (Phillips, et al., 2004); and second, it is one of the most relevant aspects of organizational isomorphism within the institutional environment (Meyer & Rowan, 1977/1991). On the other hand, terminology that has since developed and been subject to variations is still inherently problematic because it fails to capture the complexity of the problems experienced by people with concurrent disorders. At the same time, the different variations in terminology bring much diversity and confusion to this already diverse field of practice.

Institutionalization of Co-occurring Problem Gambling and Mental Health and Substance Use Problems

Regarding problem gambling services, the formal treatment of problem gambling was preceded by the expansion of state-owned gambling venues across Ontario. In the mid-1990s, the Ministry of Health formalized the position of treatment services for problem gamblers by adding resources to existing addiction services across Ontario (Ontario Substance Abuse Bureau, 1999). Throughout the 1990s, treatment for problem gambling remained a low-profile activity while addiction services attracted resources but lacked the clients to justify the additional resources. The institutionalization of problem gambling

services has been pushed ahead by the financial incentives for clinicians and researchers to formalize available treatment. On the other hand, the generous funding for problem gambling services has created new cadres of researchers, health promoters, and therapists. Among the highlighted issues that demanded more research and treatment development were co-occurring mental health, substance use, and gambling problems. The top-down approach to service development without sufficient demand for services has been one distinct characteristic of government action in this revenue-generating operation. Government policy on problem gambling remains under-developed and thus haphazard and unfocused. As one of the research participants put it, "there is no policy on problem gambling in Ontario, there are just documents produced by the government that guide the allocation of money to treatment services" (Field notes, March 11, 2008). Adding problem gambling treatment to substance use treatment services without the directed creation of a treatment system is driven by the provinces' moral obligation to individuals who have developed problematic forms of gambling. These services, however, remain underutilized (Sadinsky, 2005; Suurvali, Cordingley, Hodgins, & Cunningham, 2009) and prevention activities are under-developed. The government institutions responsible for gambling "policy" have been overwhelmed by the exposure of their own problems and scandals in the media.

The review of documents revealed that significant structural changes in the field of problem gambling services have been a part of the rationalization and restructuring of the addiction sector in Ontario. I argue that the increased focus

on co-occurring problem gambling with mental health and substance use problems has been related to the institutionalization of concurrent disorders as a concept in the provincial substance use sector. As in the case of co-occurring substance use and mental health problems, the high rates of comorbidity among problem gamblers (Hodgins, Peden & Cassidy, 2005; Rush, et al., 2008b; Shaffer & Korn, 2002) have become part of the rationale for developing treatment approaches to effectively address the complex issues of problem gamblers. Although I do not dispute the epidemiological data on this subject, my argument is congruent with Dombrink (1996) and Lindquist (2006) that changes originating in a particular sector can be transferred to or mimicked by other cognate fields and policy networks, in this case the programmatic structure of problem gambling services based on those in substance use services. I support my argument with the existence of a wide range of treatment approaches for gambling problems that have been adopted from treatment of substance use problems. Notwithstanding the isomorphic adaptation of gambling to the substance abuse sector, problem gambling services remain underutilized, despite a substantial increase in the number of people engaging in potentially problem gambling in the province. It is evident that the government and Ontario service providers must continue to raise awareness of gambling problems and their treatment. The article by Suurvali, et al. (2009) provides a summary of research on barriers to seeking help for gambling problems. Among the most commonly reported barriers were the desire to handle problems by oneself, embarrassment or

stigma, and unwillingness to admit that a problem exists, as well as concerns over quality and efficacy of treatment.

Specialization as a Legitimizing Factor

According to the findings of this study, new institutions are established through the inter-relationship among different macro and micro-processes acting upon various components of institutions (Scott, 2008). Throughout this next section, I will continue to discuss the macro-micro dynamics of organizational change. I argue that individual preferences and professional training are instrumental in the process of internal structuring and specialization of programs. Also, organizational reports, best practices, treatment manuals, and professional training are important catalysts in the diffusion of knowledge and practices related to integrated treatment.

Among the factors that facilitated the recognition of concurrent disorders as a problem in the late 1980s and early 1990s was a greater specialization of clinical research. Clinical research in addiction services focused on the subpopulations that did not benefit from traditional treatment and on the development and implementation of empirically-based treatment approaches. Although specialization of care brought positive changes in the development of evidence-based treatment, Skinner (2009) argues that the growth of specialization in both systems unintentionally contributed to greater fragmentation and disconnection of services. This, in turn, affects the main principles of care – such as holistic care - adhered to by helping professions.

Indeed, clinical diversification can be viewed from different angles. Specialization associated with the development of evidence-based practices helped the programs identified in this study gain and maintain greater legitimacy in their institutional environment. Greater legitimacy, in turn, increased the likelihood of their organizational survival. This argument is congruent with Scheid's (2004) claim that organizational conformity to diverse institutional demands leads to intra-organizational diversity. As a result, a greater variety of treatment approaches enhanced by hiring clinicians with different professional background can lead to inter-professional conflict and ambiguity in treatment ideologies.

The programs I studied became part of the institutionalization of the integrated treatment paradigm by becoming isomorphic with their institutional environment. Both the Concurrent Disorders Service and Problem Gambling Service have been transformed and have expanded the scope of services previously provided as small units in the "old" sites. Mergers have several disadvantages that can hamper organizational functionality because they bring together different cultures and organizational structures that can threaten the identity of the new organization, induce employee stress, and upset familiar organizational routines (Comtois et al., 2004). At the same time, personnel have to adopt a new or changing treatment ideology that guides clinical practice and accept the changing organizational culture in order to provide the services required by the population.

The multiple mandates that the newly-established CAMH has started to fulfill (research, treatment, education, policy consultation) have contributed to the formulation of a new treatment ideology that has reconciled the demands of institutionalized environments with the preservation of clientele. For example, as a research-based facility, CAMH is expected to adhere to evidence-based practices and implement them into its treatment orientation.

Harm reduction, adopted as the new treatment ideology, was particularly successful: the spectrum of treatment goals ranging from reducing the harm associated with substance use or gambling to total abstinence accommodated a broad range of clients and maintained support from different audiences. In human service organizations, rich ideologies have developed as a response to indeterminate technologies that do not provide unity for clinical personnel with various personal and professional backgrounds (Hasenfeld, 1992a; Scheid, 2004). Treatment ideologies in human service organizations consist of a *set* of beliefs and models held by individuals. If these beliefs and models can coexist within one treatment ideology – harm reduction encompassing abstinence as one of the goals, for example - an ideology can become collective property (Scheid, 2004; italics in the original text).

Implementing the harm reduction model among addiction professionals in the amalgamated centre has been described as a long and tedious process, conducted by ongoing training and supervision of clinical staff. I explain the difficulty of adopting a new treatment ideology as an institutionalized practice through the model of "de-institutionalization" elaborated by Kraatz and Moore

(2002). During "de-institutionalization" of models and practices to be "replaced" by newly institutionalized ones, something more than knowledge transfer and professional training is required. New mental models needed to institutionalize new ideas are better accepted if previous values and beliefs attached to established institutions are diminished or attenuated (Kraatz & Moore, 2002). Accordingly, to "de-institutionalize" the systems of personal beliefs and attitudes and professional norms that clinicians adhere to have to be questioned and altered. In the case of the two studied programs, some professionals strongly resisted change or left the organization, whereas some adapted to the harm reduction perspective that encompassed abstinence as one of the treatment goals.

On the clinical level, professional interests and specialization among individual team members is an important micro-foundation in the institutionalization of integrated treatment, particularly at the Concurrent Disorder Service. This is congruent with developments in neo-institutional theory on individual agency by Garud, Hardy, and Maguire (2007), Lawrence and Phillips (2004) and Maguire, et al. (2004).

Although the data collected in the Problem Gambling Service did not show such a direct inter-relationship between internal structuring and professional orientation, the service also specialized itself and became "unique" (P1) by approaching and serving diverse populations. This earned the program a higher level of legitimacy and isomorphism within its institutional environment.

The different characteristics of internal structuring and specialization of the Problem Gambling Service can be attributed to the fact that the program has not been mandated to provide integrated treatment for people with gambling problems and co-occurring mental health or substance use problems. However, its adaptation to the institutionalized concept of concurrent disorders was exemplified when a psychiatrist from a different CAMH treatment program was contracted to assess and consult with the clinical staff on "difficult" cases. The psychiatrist conducts "one shot" assessments and offers advice on further treatment plans; he does not, however, actively participate in the treatment. Including him on the team (on contract for limited amount of hours) could reflect demands from the clientele supported by the epidemiological data, or a ceremonial adoption to the pervasiveness of the institution of concurrent disorders in the substance use sector as a "spillover" effect of institutionalization.

Increasing Treatment Effectiveness through Silo Busting

Meyer and Rowan (1977/1991) and Hasenfeld (1992a) claim that human service organizations gain their legitimacy by becoming isomorphic with societal values, norms and expectations rather than by conforming to the efficiencies of the technical environment. The recent developments in the studies of the health care system indicate that mental health and addiction systems adopted a more business-like performance-oriented services rationale to become part of the changing institutional environment of health care services (Schlessinger & Gray, 1999). This has already become evident in the American health care system

(Schlessinger & Gray, 1999; Wells, et al., 2005), while in Ontario, incorporating more cost-efficient innovations into the organizational structures of health care services (Bigelow & Arndt, 2000; Comtois, et al., 2004) have resulted in mergers, amalgamations, or hospital closures.

The rationalization of the health care system directed by the Health Systems Restructuring Commission (HSRC, 2000) initiated the institutionalization of integrated delivery of health care services. The intention of the Commission was to increase effectiveness and quality of care by decreasing duplicity and fragmentation of services.

HSRC assumed that the merger of CAMH would increase the cost-efficiency of specialized care and create an opportunity for accessible and coordinated services. Mergers in general, however, have not proved to be an effective solution. According to Comtois, et al. (2004), the technical effectiveness of hospital mergers has been undermined by the institutional or "fashion-based' perspective that claim that the "hospital mergers wave is perhaps the result of an institutionally driven myth" (p. 305). Alleged effectiveness has been based on decreased costs through shared common resources and reduced duplicity. In stark contrast to this rationale-based perspective are claims that the adopted innovation is driven by imitation or by regulatory forces (Abrahamson, 1991; Comtois et al., 2004).

The findings of this study indicate that the amalgamation of four specialty hospitals into a large health care corporation has served as a symbol of breaking down the "silos" of the two systems. The alleged effectiveness of this merger has

not been supported by any study proving that the merger was driven by rationalizing concepts. The merger was instead supported by the increasing significance of co-occurring mental health and addiction problems in the 1990s as acknowledged by the individuals that were part of the pre- and post- merger development of CAMH (Garfinkel, et al., 1999; Kolla, Marsh, & Erickson, 2006; Room, 1999).

Drawing on institutional theory-based resource-dependence theory (Pfeffer & Salancik, 1978), it is assumed that individual actors who are more concerned with access to resources than motivations for economic efficiency gain greater organizational autonomy over their immediate environment. Observations about the CAMH merger among interviewed research participants reflect this perspective. One research participant clearly indicated that, in his opinion, the merger was a way to fulfill personal ambitions and professional goals by certain individuals rather than a response to issues surrounding the cost effectiveness of treatment for concurrent disorders.

This impression of the organizational changes at CAMH has two implications for my findings: one is to accord to Buchanan and Dawson (2007), the postulate that organizational change can be presented through varied, polyvocal narratives. Second, this impression guided my analysis towards a closer examination of institutional entrepreneurship as the ability by individuals to intervene in their immediate environments (Garud, Hardy, & Maguire, 2007; Lawrence & Phillips, 2004; Scott, 2008; Zilber, 2007). When suggesting this in the interviews some of the participants did not feel confident in judging whether

this "version" of the rationale was valid or not. Others doubted that a big change, such as the merger, could have been accomplished by the actions of a few highly motivated individuals. These findings added to the multiplicity of interpretations of integrated treatment. From studying organizational changes, it is necessary to include multiple even conflicting interpretations of these events. I included this information in my findings as an example of the equal value given to all personal narratives of organizational changes. This concurs with Buchanan & Dawson (2007) who called for developing fully informed case studies that combine narratives and process and context analysis.

Barriers to Integrated Practices

The integration of administrative and bureaucratic structures does not necessarily promote integration at the clinical level. Different ideologies of care, funding restrictions, capacity issues due to increased demand for services, and problems with effective communication across the organization can cause individual programs to become "silos" as well.

While a few examples of the successful "prototypes" of integrated services have emerged and managed to operate within a disconnected system, the Concurrent Disorders Service has most closely integrated its services at CAMH and fulfilled its specific mandate. I observed positive sentiments towards the Concurrent Disorders Service among clients who had an opportunity to receive integrated treatment at the specialized clinics; however, long wait lists still prevent people from receiving this much-needed treatment.

Some of the clinical staff compared the specialized programs of the Concurrent Disorders Service to "little boutiques" for their limited capacity to serve the larger clientele with concurrent disorders in a broader sense of integrated care across the organization. This metaphor, although critical to the clinics, has two implications for my analysis. First, it can be interpreted through the concept of "fashion" in the adoption of organizational change (Abrahamson, 1991; 1996; Czarniawska & Joerges, 1996); it is usually associated with modernity, progress, and the incorporation of novelties. Through pioneering new concepts and ideas, "fashion" becomes part of the diffusion and translation process of organizational change. The fashion perspective also assumes, as does DiMaggio and Powell's (1983/1991) mimetic isomorphism, that in conditions of uncertainty, organizations imitate models promoted by fashion-setting organizations (Abrahamson, 1991; 1996). I argue that new concepts such as integrated treatment for concurrent disorders have been diffused with the help of "opinion leaders' who purposefully selected and promoted these models to render them fashionable in their organizational field. I also conclude that promoters and adopters of new concepts increase the legitimacy of a fashion-setting organization.

I employ the "fashion" perspective for viewing the diffusion of the concept of integrated treatment for concurrent disorders; CAMH became part of the innovation process with its individual actors that brought the new and desired changes. Abrahamson (1991; 1996) elaborates on the role of "fashion setters" and "fashion followers". I use this model to interpret the leading role of the

American scholarship in concurrent disorders as "fashion-setting" activity, while CAMH acted as a "fashion follower": an actor who translates the fashionable techniques into practice. An example is the *Best Practices* report (Health Canada, 2001) where the prevailing data on concurrent disorders and the need for integrated treatment came from the United States. The "fashion follower" could be defined as someone who is led passively to conclusions, however, those who adhere to 'fashionable' practices early on become leaders themselves and, as Abrahamson (1996) characterizes it, nothing like a "sheep". On the clinical level, when dialectical behavioural therapy for co-occurring borderline and substance use disorders became a empirically supported practice (Linehan, 1993; Linehan et al., 2002), it acted as a good example of utilizing novelty in continually innovate ways; the staff trained in the model became a close adherent to and promoter of that model.

The second implication of the "little boutiques" metaphor reflects various reasons for the low capacity of some of the programs at the Concurrent Disorders Service, the most obvious of which is recognizing the value of this resource to the community despite limited resources or high demand for these specific specialized services. This can be also interpreted through the "fashion" perspective. The main motive for adopting new "fashionable" models can be the desire to signal innovation, instilling hope, or improving an image. In this regard, organizations often adhere to such models only symbolically (Abrahamson, 1991). Also, over time, when the symbolic value of the innovation decreases, difficulties in maintaining them as a routine practice resurface. For example, the

Dialectical Behavior Therapy clinic based on an evidence-based model of treatment lacked the resources to provide a comprehensive model of treatment; and the Integrated Group Therapy clinic, providing treatment to clientele with severe and persistent mental health and substance use problems, has been unable to provide regular long-term care. Finally, if the problems persist, an organization may tend to lose interest in the once "fashionable" concept and begin seeking new alternatives again.

The findings indicate that to "spread" integrated practices across a centre that includes integration in its mandate, enhancement of the skills and competencies of clinicians at CAMH that relate to concurrent disorders is one option. A team of clinicians from the Concurrent Disorders Service have served as a liaison team for more efficient coordination of care across CAMH. The team's initial goal was to build the capacity for treating concurrent disorders within CAMH's mental health programs which mirrored the general lack of knowledge on addictions in the larger mental health sector.

Giving such a large task to a small team of clinicians has received mixed reviews from clinical staff and program management at CAMH. Although positive partnerships have been made outside of CAMH in the larger community, this form of institutionalization of integrated treatment across and outside of the centre has been an overwhelming task for a relatively small team in a compartmentalized, systemic, and organizational structure.

Individual Agency in the Institutionalization Processes

The analysis of my findings as they relate to the value of individual actions concurs with Scott's (2008) understanding of the concept of agency as the way in which both individuals and organizations innovate and attempt to diffuse organizational change. This concept clearly acknowledges that both individual and collective actors posses the variety of abilities needed to enact change. These abilities are, however, socially and institutionally constructed. The role of social actors in enacting, producing, and reproducing social structures is discussed in the following sections.

Theorizing institutionalization is a process of inter-dependent actions between organizational structures and individuals. Employees and other individuals influence and are influenced by discourse-related activities that shape practical action, a concept developed in Phillips et al. (2004). The analysis of organizational texts and language surrounding the provincial reorganization of mental health and addiction systems also indicate that the logic for integration was shaped by broader cultural and social pressures. Organizational changes triggered by the adoption of rationales of economic efficiency and efficiently coordinated access to services became diffused through adopted metaphors, symbols, and platitudes.

In this way, CAMH, following Tolbert and Zucker (1996), became a "champion" of change and innovation. The change and innovation have been enacted through objectifying and diffusing new notions and concepts, particularly that of concurrent disorders. In this case, the champion as a moving force

emerged in a broader provincial health care landscape where the interest in promoting the logic of integration was very high. At the same time, CAMH introduced the institutional change it was championing to the broader environment by taking up the rhetoric of integration internally and launching its own integration project in concurrent disorders. It presented itself as the manifestation and embodiment of this new logic of integration. The successful diffusion of novelty is effected by the position of such a social actor. It is evident that CAMH has possessed, from its inception in 1998, the organizational characteristics that, according to Maguire, et al. (2004), help maintain and extend both its own legitimacy and the legitimacy of the integration project. With its provincial mandate for education, health promotion, research, and public policy, its service to diverse populations, and the benefits of its geographical location (Ontario's and Canada's largest city), CAMH can be considered a precedent-setter that shapes the broader institutional environment.

My findings also concur with the concepts of Strang and Meyer (1993) who state that "champions" emerge during periods of substantial environmental change; in this case, the rationalization of both mental health and addiction systems in Ontario during the 1990s and the changes that were made in the new millennium. To become a successful adopter and penetrate the field with innovative organizational structures, "champions" have to be able to explain and "theorize" their actions effectively (Strang & Meyer, 1993; Tolbert & Zucker, 1996). Theorization is a key process in the institutionalization of novelty. When new concepts become diffused among heterogeneous adopters, the level of

theorization increases. It is important to understand the activities of CAMH in the institutionalization of integrated treatment not only through the model of theorization, but also individual agency.

CAMH also used its central role in provincial and national mental health and addiction systems by being highly "visible" as a service provider and an advocate for reducing stigma related to mental health and addiction. CAMH has since become an important actor in shaping the institutional environment of mental health and addiction services in Ontario. That has continued with, for example, the recognition by LHINs of the importance of concurrent disorders as an organizing perspective for addiction and mental health services throughout the province. The result of this has been acknowledging concurrent disorders as a priority area in 12 out of the 14 newly-established LHINs that hold legislative power over integration, coordination, and funding of health care services across the province.

A review of clinical and systems research, publications, annual reports, media coverage, and interviews of research participants show that the integration of treatment for concurrent disorders has become a legitimized concept. This has been reflected in the financial support for research and capacity building initiatives that themselves help further institutionalize the integration "movement".

The significant activities regarding individual agency and theorization include the development and distribution of influential organizational texts. Integrated treatment has, over the past decade, been seen as a standard of practice for treating co-occurring mental health and addiction problems. This is

largely due to the contribution of the publication and dissemination of Health Canada's *Best Practices: Concurrent Mental Health and Substance Use Disorders* (Health Canada, 2001). This document was successfully disseminated by social actors interconnected via professional networks and relationships inside or outside of CAMH, in Ontario and across Canada. Health Canada contracted with CAMH and other experts to produce a report that addressed two problems that had been much discussed and contested: the prevalence of co-occurring substance abuse and mental illness and how they should be treated. This report remains significant as it reviews evidence-based practices in the treatment of concurrent disorders and emphasizes the heterogeneity of the affected population. The dissemination of knowledge through the training of different professional audiences by the CAMH staff enhanced inter-organizational learning that, according to Kraatz and Moore (2002) and Scott (2008), is part of the micro-processes affecting the normative components of institutions.

Eight years later, when the rhetoric of integration in Ontario has become omnipresent with little consensus on the operational practicalities of integration, another text, *On the Integration of Mental Health and Substance Use Services and Systems,* has emerged (Rush et al., 2008a). This paper was prepared by the same project lead as the *Best Practices* report (Health Canada, 2001) and was commissioned by the Canadian Executive Council on Addictions, a recently established national advocate for improving addiction services in Canada. The Council later accepted the report's recommendation in its formal position statement on the integration of mental health and addiction services and

systems. This text, (Rush et al., 2008a), providing a detailed analysis of the available data on integration in the United States and Canada, serves as a cautionary reminder that the integration of mental health and addiction services has become a rationalized myth without attending to the little evidence for the practical effectiveness of systems and service integration. At the time of writing this discussion, it is difficult to predict the fate of this report. DiMaggio and Powell (1983/1991) and Meyer and Rowan (1977/1991) assert that different rationalities have to be accepted by organizations in order to create new institutionalized concepts in a given field. Kraatz and Moore (2002) also explain "de-institutionalization" as the acceptance of new rationalities needed for the institutionalization of emerging ideas to be better accepted if previous values and beliefs attached to established institutions are diminished or attenuated.

The reasons for re-evaluating the integration "movement" at this time need to be identified and openly discussed among the social actors involved in the diffusion of new practices. In this regard, the newest report developed by Rush and his associates (2008a) for the Canadian Executive Council on Addiction as a position paper on integration can hardly adjust the rhetoric of integration in its favour, if the previous rationalities for integration remain unchallenged.

Can it be that the acceptance of an axiomatic understanding of concurrent disorders is itself a barrier to the development of a more nuanced and specified approach to responding to the complexities of clients with addiction and mental health problems? It may, in retrospect, be recognized as part of a development process that started with a categorical valorization of integration and is moving

towards a more evolved and detailed iteration of specific problem clusters and clinical populations for whom integrated treatment is the best practice. It could be perceived that the addiction system has been ambivalent about integration much in the same way as a rabbit, who being urged to work alongside a wolf, might have some trepidation, even if circumstances have given them common cause for collaboration. Ironically, the findings of Rush's review are that the concurrent disorders of addictions clients are more common than those of the mental health clinical population. But as a demonstration in the growth of knowledge, this example represents moving beyond concurrent disorders as a basic tenet towards a more elaborate and specific description of concurrent disorders.

Striving for Treatment Efficiency

In this section I will argue that the advent of technical considerations related to treatment efficiency and treatment outcomes undermine the concept of client-centered, long-term care that should be included as a treatment aspect for people with complex problems, including concurrent disorders.

The pressure to conform to technical efficiencies when treating concurrent disorders has impacted institutional environments in addictions and mental health, as they have in health care and social service in general; that is the professional prerogative (clinical autonomy) has been undermined by the concept of technically driven efficiency of treatment. Although the role of treatment manuals and protocols is to enhance the quality of provided care

through evidence-based practices, D'Aunno (2006) reports that treatment protocols are used as one of the mechanisms to control the content of provided treatment and the operation of the organization itself. Other forms of control include financial mechanisms (paying units on a per capita basis) and the rationing of resources through administrative mechanisms (rules concerning number of sessions and length of treatment).

In this regard, some of the clinical practitioners interviewed felt that, since they provide services to a population with multiple problems, technically driven treatment efficiencies conflicted with the principles of client-centered care they wanted to adhere to. According to Townley (2002), the clash of different rationalities can bring inconsistencies to the process of instilling organizational change and effective functionality. This conflict was clearly present in the views of the clinicians providing comprehensive and, if needed, long-term care who considered these to be the better options for preventing client relapse and deterioration in other areas of adjustment. The adopted rationalized myth on treatment outcomes measured through throughput, (the efficient admission and discharge of clients), contrasts with the need to address the complex conditions of clients with chronic and severe concurrent disorders.

7.2 Concluding Remarks

As noted in the introduction, this study has an exploratory character. I do not claim that the processes leading to establishing integrated practices for concurrent disorders have been present in other organizations similar to CAMH. In fact, I do not extend my study beyond the mental health and addiction environments in Ontario. My findings contribute to the discussion for making integrated treatment practices part of the formal structure of CAMH. I found this element of the institutionalization of integrated treatment for concurrent disorders lacking in previous studies. This study was designed to approach that lack in previous studies by incorporating discussion on the value of integrated treatment evident at CAMH. At the same time the study helped identify organizational characteristics of integrated treatment and explore the links between different levels of organizational functioning in my two cases. The findings illustrate the value of a comprehensive approach to the understanding of the organization of integrated treatment, particularly the challenges stemming from internal and external forces.

Chapter 8:

Conclusion

Introduction

In this final chapter, I elaborate upon some of the key findings and theoretical contributions of this research study. First, in section 8.1, I will offer the recommendations that arose from this study. I outline some of the key thematic implications for addiction services following research into two of that service's programs. I also provide recommendations that pertain to social work practice. In section 8.2, I will discuss the contribution of this study to the theoretical framework that I utilized for the interpretation of the findings. Following this, I will critically examine the contributions and limitations of this research by referring to the purpose and goals of this study and outline the directions for future research.

8.1 Implications for Social Work Practice

From a practical perspective, this study helps to analyze the social, institutional, and organizational impact of existing organizational arrangements on the treatment of concurrent disorders. A better understanding of the factors contributing to the development and subsequent implementation of treatment for concurrent disorders is useful for policy makers, program managers, clinicians, and service users.

Based upon the findings, I believe that the demand for integrated treatment among populations with concurrent mental health and addiction problems is a valid argument for providing integrated treatment. This is based upon the countless experiences of concurrent disorder clientele with services that could not provide sufficient support due to the institutionalized barriers created and maintained in previous mental health and addiction systems (Health Canada, 2001; Kirby, 2004b). Also, as a Social Worker and a former clinical practitioner, I recognize the struggle and frustration of many clinicians constrained by divided ideological, administrative, and funding systems that they must incorporate into their efforts. These constraints are perpetuated by structural arrangements stemming from economic, sociopolitical, and cultural factors. Defining mental health, addiction, and concurrent disorders as individual client-based phenomena rather than being related to the existing social order prevents social workers from becoming part of an accessible and responsive system of services. This has been enriched by insights developed after a studied analysis of the problem through the lens of neo-institutional theory.

I have explored and analyzed the rationalities that have been used in the processes of enacting and reproducing integrated treatment as a new institution. These rationalities that became taken for granted as knowledge demand the following recommendations. In accordance with recent reviews of the prevalence of comorbidity in general and clinical populations reviewed in the Rush et al. (2008a) second report, closer attention should be paid to different severity levels and diverse subpopulations of individuals with concurrent disorders.

Epidemiological studies should not remain the sole source of information on concurrent disorders. They are unable to capture the full complexity of the problem or identify certain subpopulations that underutilize the treatment services. Thus, another problem is that the clinical data that serves as a basis for planning services and interventions represents only a fraction of those affected and therefore does not reflect the needs of the larger population. Flynn & Brown (2008) argue that only seven to eight percent of clients experiencing concurrent disorders receive mental health and addiction treatment simultaneously and only 15 percent receive simultaneous treatment when severe mental health and addiction problems are present. These challenges can be addressed by adopting different strategies for identifying and assisting people with concurrent disorders receive treatment from available services. The role of outreach and community partnerships in accessing hard-to-reach populations are some of the areas social workers could utilize.

Social work practitioners for concurrent disorders should, apart from acknowledging contextual forces shaping their daily encounters with clients, engage in practices that reflect anti-oppressive perspectives such as empowerment and the right of clients for self-determination. By sharing power and expertise with their clients and by focusing on clients' strengths and unique attributes rather than on their problems, symptoms, and weaknesses (Saleeby, 2009; Walsh, 2006) social workers have yet another avenue available despite significant organizational and societal barriers.

Over-reliance on quantitative data in research and treatment evaluations driven by cost-efficiency does not accommodate the exploration of other clinical initiatives that could exceed the capacities of "typical" addiction treatment programs. It is hard to comprehend that the accumulated problems of concurrent disorder populations attributed to the inadequacy of treatment interventions are not therefore provided with services focusing on continuity of care. Long-term treatment and support with various life adjustments should become standard for populations in need of such services. I illustrated this point in Chapter 6 with a testimony of one client who has been struggling with depression, anxiety, and alcohol problems throughout his adult life. It was only when his conditions were assessed and treated simultaneously over the extended period of time that he experienced significant changes in his quality of life. Recommendations from the evidence-based community treatment for severe mental health and substance use problems developed by Mueser, et al. (2003) and Drake, et al. (2004) also emphasize the need for long-term treatment and the continuity of care that allow clients to live more productive lives. More research is needed to examine whether the provision of longer term treatment can make a significant difference for larger numbers of individuals with concurrent disorders – and if so, for which specific sub-groups of this population. It is necessary to develop and implement such effective practices that would reach beyond a limited number of clients so that they may receive adequate treatment of their concurrent disorders. Such changes need to be addressed on policy and clinical levels. With regard to the standardization of provided care, the increased professional prerogative and

greater clinical autonomy in treatment planning can facilitate the delivery of services that respond to individual client needs and reflect clients' rights to self-determination in their recovery process.

On the systemic level, as a consequence of the institutionalization of integrated treatment, it has been argued that both mental health and addiction treatment services should be prepared to serve populations with concurrent disorders. Provincial and nation deficits that have recently become apparent will likely affect services negatively for these vulnerable populations. Addiction services have long been challenged by the multiple, negative consequences of drug use (physical, legal, economic, personal, etc) and not only with regard to substance use or dependency alone. Treating concurrent disorders can become an onerous additional task that addiction services may not be prepared to deal with without sufficient resources and support. One of the implications of integration that should be considered is the additional pressures placed on already constrained services. In this sociopolitical context, social workers have to challenge the rationalities of cost-containment and become strong advocates for client-centered care.

Addiction services, historically experiencing minimal recognition among other health and social services, need to re-examine their ability to undertake initiatives specific to concurrent disorders. As one of the research participants noted, the addiction sector might have incorporated the concept of concurrent disorders into the expectation of greater recognition and increased legitimacy.

However, without sufficient resources this task can represent an additional burden that may, in fact, jeopardize the current service structures.

In formulating another recommendation, I will use an analogy presented at the provincial webinar organized by CAMH on the integration of mental health and addiction systems and services: the mental health system was symbolized as a moose that could swallow the much smaller addiction system, represented as a squirrel (Field Notes, February 14, 2009). This could support a re-examination of the integration "movement" as a threat to the addiction system by representing integration as the "absorption" of addiction services into the mental health system.

Also, it is in the best interest of those receiving treatment for concurrent disorders to discuss the existing rationalities publicly and thus engage different viewpoints in the debate. In Chapter 6, I provided an account of the recent initiative of the Canadian Executive Council on Addiction to reflect on the integration "movement" across the mental health and addiction systems. Although I welcome this initiative and studied the subsequent report closely, I want to emphasize that the emerging rationalities behind this critical reflection should also be examined and discussed when attempts to re-evaluate the institutionalized concept are pursued by different social actors. One could ask why this initiative is taking place at this point in time and why it was undertaken by this non-governmental body comprised of five of the most influential organizations in the Canadian addiction sector.

Social Work by nature operates in a contested terrain of health and social services affected by structural arrangements involving various external and internal pressures. One specific recommendation for Social Work practice, arising from this study, is that the profession must become more attentive to organizational critiques of integrated practices for concurrent disorders.
I recommend that social work educators include organizational theory critiques into the classroom and encourage and facilitate discussion that will help balance future social work in existing organizational arrangements.

Social work educators should also closely examine and critique current organizational arrangements related to newly promoted treatment options for concurrent disorders. Social workers play an important role in service planning and service delivery and it is important that they examine, discuss, and challenge the rationalities used in establishing new institutions for this vulnerable population. In such a discussion, diverse viewpoints including those from clients and their significant others can raise awareness about the complexity of the problem and the consequences of political rhetoric over real practice.

Also, organizational practices analyzed through critical research should find a place in Social Work research and education. Although there have been scholars that have introduced the tenets of institutional theory into Social Work research on organizations and used this framework to promote awareness on organizational behavior (Hasenfeld, 1992a; 2000; Rains & Teram,1992; Teram, in press b), more research is needed to illustrate the value of a comprehensive approach to the understanding of organizations. Social Work scholarship can

contribute to future research on ideological, organizational, and professional aspects of institutional processes.

8.2 Theoretical Implications of the Study

I was guided by both theoretical and practical considerations when conducting this case study. On the theoretical level, applying concepts of neo-institutional theory provided a framework for understanding integrated treatment for concurrent disorders that takes into account the broader social, economic, and political context of service development and implementation. This is the first study that has analyzed the topic of integrated treatment for concurrent disorders from this perspective.

The scope of the studied topic - two systems: mental health and addiction, including problem gambling - involved some challenges during data collection and analysis. These systems, although both equally stigmatized, have undergone different evolutionary processes. The aetiology of mental health and addictions problems have some common ground but can differ substantially depending on which theory is applied. Second, different moral assumptions have been associated with mental health, substance use and problem gambling. These differences have deepened over time and have affected the way services are supported and delivered.

Another relevant issue is that literature on mental health and addiction systems for this research was drawn from disciplines outside of social work to

provide a context for analysis within a specific theoretical framework. I consider this to be the strength of my study; it facilitated a more intensive examination and understanding of the systems that were shaped through the actions of several professional disciplines.

The main theoretical contribution of this study is that it demonstrates an analysis that integrates the macro- and micro-foundations of institutional processes into one interconnected conceptual framework. Earlier developments in institutional theory that I reviewed provided an account for organizational processes-based on a macro-level analysis. Therefore, during the data collection and analysis, some of the findings appeared to lack connections with the theoretical framework utilized. It was only after I reviewed recent developments of the theory with respect to different aspects of institutionalization - analysis of organizational language, texts and metaphors, the dynamics of institutional entrepreneurship as well the studies on organizational change as a multifaceted process of "translation" – that the data could be interpreted.

This conceptual framework is not common for social work scholars even though it can provide unique insights into social work practice by depicting the nuances of organizational factors in delivering services for concurrent disorders. Neo-institutional theory has a predictive value in its ability to uncover the dynamics of organizational change and to clarify the decision-making processes in planning and delivering health and social services.

8.3 Concluding Remarks on the Contributions of this Study

The main contribution of this study is its critical examination of the institutionalization of the development and implementation of integrated treatment for concurrent disorders. From a practical perspective, this research explores and analyzes the policy, organizational, and individual factors that facilitate an understanding of the need to make integrated treatment a priority in the provincial mental health and addiction systems.

By employing an institutional case study, I incorporated multiple sources of information. The data collection methods (document review, participant observation, and interviews) combined elements of personal accounts of organizational change with the analysis of ongoing organizational processes and contexts. It also utilized the narratives of individuals experiencing the various attempts to provide integrated treatment on different levels: higher management and clinical practitioners as well as clients and their family members.

The contribution of institutional theory as a framework has already been discussed in the previous section; however, there are certain limitations that must be recognised to optimize its use and interpretive value. The interpretation of these findings does not explicitly attempt to explore the underlying power dynamics in the institutionalization of integrated treatment. Neo-institutional theory usually downplays the conflicts of interest and the power relationships (DiMaggio & Powell, 1991). I, on the other hand, treat power as implicitly omnipresent and ever-changing and as backdrop for understanding the two

studied programs. These programs have been part of organization-influencing research, social policy, and public attitudes towards mental health and addiction problems. Another limitation of this study is that it is relevant only to the province of Ontario. Studying variations of the institutionalization of integrated treatment in different jurisdictions remains a task for future research.

Future Research

The rationalities behind the integration of treatment for concurrent disorders are present at different bureaucratic, managerial, financial, programmatic, and individual levels. This study uncovered how organizations introduce, change, and adopt innovation and how they adapt to their changing environments. More detailed studies of the complex sets of decisions and collaborative practices have great potential to reveal the development of new practices in the field of concurrent disorders. Future research on integrated treatment for concurrent disorders would benefit from a close examination of the competing rationalities of different key groups involved in the promotion of new treatment arrangements. In fact, this study is the first that examined integrated treatment for concurrent disorders through organizational analysis; it provides many routes that could be explored in more detail. For example, problem gambling services that have been formally included in the substance use sector could experience changes driven by rationalities for integrated practices as witnessed in the substance use sector. These changes should be carefuly planned and implemented. The influential agency of individuals in both sectors is

another avenue to be explored through greater attention to power dynamics. Several of the factors discussed in this study are structural in nature but closer examination of large scale policy changes to improve treatment for concurrent disorders is ongoing. On the clinical level, research that could uncover levels of shared decision making between client and service providers and how that is constructed would be important in advancing clinical skills. It is hoped this study will inspire others to continue the discussion and exploration of infrequently considered organizational issues as they affect treatment development, implementation and effectiveness.

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Appendix A

Questions for the semi-structured interviews
Interview Guide

Questions and probes are placed into three categories related to multiple levels of inquiry and analysis of the proposed research.

1. *Policy level: Questions related to policy and policy measures (policy makers, researchers, external stakeholders)*
    - Can you tell me how integrated treatment for mental health and addiction problems came about?
    - What do you think led to the development and implementation of integrated treatment for people with concurrent disorders?
    - Are there any bureaucratic, financial, managerial, or ideological issues that you can think of as being related to the development of integrated treatment for concurrent disorders?
    - Has integrated treatment been achieved? What are the barriers and challenges that affect the future of integrated approaches to treating co-occurring addiction and mental health problems?

2. *Organizational level: Questions related to organizational and programmatic function of services provided to people with concurrent disorders (service managers, clinical directors)*
    - Can you tell me how integrated treatment evolved/ came about?

- What are the policy measures that influence how this program operates now?
- How this program reacted to changes on policy level in the area of integrated treatment?

3. *Individual level: Questions related to clinical practice and perspectives of clinicians on integrated treatment of concurrent disorders:*

   Clinicians:

   - How do you think integrated treatment for concurrent disorders came about?
   - Can you explain, what is this program's perspective on integrated treatment for people with concurrent disorders? How is this perspective expressed in the way the treatment is organized?
   - What is your professional approach to integrated treatment for people with concurrent disorders? What factors play the role in forming your professional approach/attitude towards clients?
   - Are these attitudes shaped by your individual beliefs and values? If yes, can you tell me how?
   - In the organizational environment in which you work, what does the future of integrated treatment look like?

Clients:

- Can you tell why you are here and what treatment you are currently receiving? (Additional probes will be directed to find out if a client is currently experiencing problems with both mental health, substance use or gambling problems and if the treatment he/she is receiving is directed to helping with both types of problems).
- If a client is currently receiving treatment that addresses more than one problem, questions will be directed to find out more about client's experiences receiving treatment, e.g.: "What has it been like getting treatment from addiction and mental health services under one roof?" 'What do you think why you are currently (at this time) receiving treatment for both problems? "What's it like to be here?" "What is it like to be getting help here?" "What happens when people come here?"
- Do you have any previous experiences getting mental health and addiction services that were not integrated or not provided in a coordinated manner? What are the main differences between these two?

Client advocacy groups:

- What is your understanding of integrated treatment for people with co-occurring mental health, substance use or gambling problems? Have you ever been treated or do you know somebody who received treatment in a program that simultaneously addressed the treatment for psychiatric disorders and substance use or gambling problems?

- Do you think the Concurrent Disorders Service at CAMH provide integrated treatment? Do you think that the Problem Gambling Service should attempt to provide integrated treatment for comorbid gambling and substance use problems or mental health problems?
- What do you see as the main factors influencing how treatment is provided to clients with concurrent disorders? What else could be done to ensure the complex needs of this population are met?

Appendix B

List of Interviewed Participants

Participant 1: Management, CAMH

Participant 2: Management, CAMH

Participant 3: Clinical Work, CAMH

Participant 4: Clinical Work, CAMH

Participant 5: Clinical Work, CAMH

Participant 6: Clinical Work, CAMH

Participant 7: Research, CAMH

Participant 8: Public Policy, CAMH

Participant 9: Clinical Work, CAMH

Participant 10: Management, CAMH

Participant 11: Management, CAMH

Participant 12a, b: Management, CAMH

Participant 13: Management, CAMH

Participant 14: Family member of a client with concurrent disorder receiving treatment at the Concurrent Disorders Service, CAMH

Participant 15: Clinical Work, CAMH

Participant 16: Family member of a client with concurrent disorder receiving treatment at the Concurrent Disorders Service, CAMH

Participant 17: Management, CAMH

Participant 18: Client, the Problem Gambling Service, CAMH

Participant 19: Management, CAMH

Participant 20: City of Toronto

Participant 21: Client, the Concurrent Disorders Service, CAMH

Participant 22: Clinical Work, CAMH

Participant 23: Client, the Concurrent Disorders Service, CAMH

Participant 24: Clinical Work, CAMH

Participant 25: Clinical Work, CAMH

Participant 26: Research, CAMH

Appendix C

List of Reviewed Organizational Documents

CAMH Strategic Plans and Annual Reports

- CAMH Annual Report to the Community 2008-2009
- Celebrating 10 years: CAMH Annual Report 2007-2008
- Making Connections: Integration in Mental Health and Addiction, CAMH Annual Report 2006-2007
- CAMH Strategic Plan Renewal, Environmental Scan, October 2005
- From Discovery to Recovery: Transforming Lives and Promoting Health, Implementing CAMH's 2003-2006 Strategic Plan, Highlights
- CAMH Foundation Annual Report (2006-2007): You are Transforming Lives

CAMH Internal Periodicals/Newsletters

- Breakthrough: News About the CAMH for Clients, Patients and Families (Winter, 2007/08; Spring, 2008, Summer 2008; Fall 2008)
- CAMH Connexions: A quarterly publication of the Centre for Addiction and Mental Health (I,II,III,IV 2008)
- CAMH Insite News: News for CAMH Staff and Volunteers (March/April 2008; September/October 2008)
- CAMH Accreditation News, September 2007, November/December 2007
- Information Sheet for Staff re Accreditation On-Site Survey, June 9-13, 2008
- CAMH and Canadian Mental Health Association (CMHA): Fact Sheets: Mental Health, November 2005
- CAMH and Canadian Mental Health Association (CMHA): Fact Sheets: Addiction, November 2005

CAMH Treatment Manuals and Guides

- Concurrent Substance Use and Mental Health Disorders: An Information Guide, CAMH, n.d.
- Navigating Screening Options for Concurrent Disorders: Resource for Clinicians, Concurrent Disorders Screening Tools Advisory Committee, 2006; Knowledge Exchange Area
- O'Grady, C.P. & Skinner, W. J. (2007). Partnering with Families Affected by Concurrent Disorders: Facilitators' Guide, CAMH.

CAMH Mission Statements

- CAMH Family Council Mission Statement, The Family Council, n.d.
- Empowerment Council: Clients Bill of Rights

CAMH Reports

- Smaller World Communications, Ltd: Your Organization: Your Views, CAMH Employee Survey, Corporate Report, February 2002
- CAMH Accreditation Survey Report, March 6-11, 2005
- Enhancing Concurrent Disorders Knowledge in Ontario: A Report of the Concurrent Disorders Training Strategy Work Group, CAMH April 2004
- Calderwood, K. and Christie, R. Increasing Linkages between Addiction and Mental Health Services in Ontario. Final Report on the Concurrent Disorders System Models Project, February, 2003
- Macfarlane, D., & Durbin, J. Mental Health and Addiction Services in Regionalized Health Governance Structures: A Review. CAMH-HSRCU, March 2005
- Smythe, C., Powell, B., Murphy, L., Pulford, R. Results of the Survey of Mental Health and Addictions Agencies in Ontario for Concurrent Disorders Screening and Assessment Tools, CAMH, October 2003

CAMH Organizational Documents and Forms

- Organizational Charts, November 2000; October 2007, September 2008
- CAMH Provincial Services Program Phasing
- Addiction Functional Program Description, Addendum, Revised December 13, 2006
- Operating Plan 2006-2007, Problem Gambling Service, CAMH
- Performance Assessment and Communication Tool (PACT), CAMH
- CAMH Problem Gambling Service Job Descriptions: Therapist I and II, Intake Coordinator, Research Analyst
- Request for Consult In-Service Form
- Request for Consult Form. Concurrent Disorders Consultation-Liaison Service
- Twelve Core Functions of the Alcohol and Drug Abuse Counselor

If you have questions about the study that are not answered in this consent form, please ask them. In addition, if you have questions in the future you may contact the study investigators at the telephone numbers given on the first page. Dr. Padraig Darby, Chair, Research Ethics Board, Centre for Addiction and Mental Health, may be contacted by research subjects to discuss their rights at this phone number: 416-535-8501, ext. 6876.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed. You have the right to omit any question(s)/procedure(s) you choose.

FEEDBACK AND PUBLICATION

The findings of this study can be used for the purposes of publication, ensuring your anonymity. If quotations are used for publication there would not be any information that could identify you as a participant.

Do you want to be informed by the researchers when the doctoral dissertation or other published material based on this study becomes available to public?

Yes No

CONSENT

Do you agree that a transcriber can be hired under the condition that s/he will follow ethics standards related to this study with an emphasis on maintaining the confidentiality of your personal information?

Yes No

If transcriber is not hired, the investigators will transcribe the audiotapes.

If a transcriber is hired, do you want to be provided with his/her name?

Yes No

Do you want to be contacted in order to give feedback on the preliminary results of this research study?

Yes No

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Participant's initials: _____

Research Participant:

Name (please print):_____ Signature:_____ Date:_____

Student Researcher:

Name (please print):_____ Signature:_____ Date:_____

If you have questions about the study that are not answered in this consent form, please ask them. In addition, if you have questions in the future you may contact the study investigators at the telephone numbers given on the first page. Dr. Padraig Darby, Chair, Research Ethics Board, Centre for Addiction and Mental Health, may be contacted by research subjects to discuss their rights at this phone number: 416-535-8501, ext. 6876.

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Yes No

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Research Participant:

Name (please print):_____ Signature:_____ Date:_____

Student Researcher:

Name (please print):_____ Signature:_____ Date:_____

List of Abbreviations

ARF	Addiction Research Foundation
CAMH	Centre for Addiction and Mental Health
CECA	Canadian Council on Addictions
HSRC	Health Systems Restructuring Commission
LHINs	Local Health Integration Networks
MoHLTC	Ministry of Health and Long Term Care
OSAB	Ontario Substance Abuse Bureau
SAMHSA	Substance Abuse and Mental Health Systems Administration