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Facilitating Social Integration for People With Severe Mental Illness Served by Assertive Community Treatment

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A B S T R A C T

Purpose: This article explores the experience of workers on Assertive Community Treatment (ACT) teams surrounding their efforts to facilitate social integration for their clients.
Design and methods: Sixteen workers were individually interviewed and eight additional workers participated in two focus groups.
Findings: The formation of caring relationships between worker and client was an important first step towards social integration for ACT clients. Community activities offer opportunities for social interaction.
Practice implications: The frequency of community based activities should be increased. Social integration should be a targeted focus of service by structurally embedding a social integration specialist onto the ACT model.
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Following deinstitutionalization in the 1960s, community based services replaced the state hospitals in the United States as the primary provider of mental healthcare for people with severe mental illness (SMI), (Drake et al., 2003). Without adequate community supports, individuals with SMI often became homeless or filtered into the prison system (National Alliance on Mental Illness [NAMI], 2010). To address this problem, Assertive Community Treatment (ACT) was developed by Stein and Test (1980) to support individuals with SMI who did not attend mental health clinics, were not able to function independently in the community, and were socially isolated (Bond et al., 2001; Drake et al., 2003; Stein & Test, 1980). ACT teams comprise a variety of disciplines including nurses, social workers, and psychiatrists working together to provide comprehensive psychiatric and social services to clients in their homes (Rosen et al., 2007). ACT is evidence based, and has proliferated across communities in the United States (Gold et al., 2003) and abroad (Clausen et al., 2015; Nishio et al., 2012; Stobbe et al., 2014). In developing ACT, Stein and Test endorsed social integration noting the importance of improved quality of life (QOL) with an emphasis on community involvement and improved psychosocial functioning. However, ACT clients continue to complain of social isolation and loneliness (Scheyett et al., 2010; Stull et al., 2010). This deficit in services that support ACT's own QOL goals has been minimally researched. Thus, this study attempts to learn firsthand from ACT workers about their attempts at facilitating social integration, the barriers they faced, and their suggestions for improving the ACT model in relation to social integration.

BACKGROUND

The understanding that people with SMI can recover from mental illness is the driving force of mental health service delivery in the United States. It is suggested that recovery goals may be achieved through managing one's health and illness, in securing housing stability, and in finding meaning in life through daily activities, social networks, and community participation despite having symptoms of mental illness (The Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). We looked at the facilitation of social integration within ACT services using this concept of recovery.

Impact of Social Isolation and Loneliness on Mental and Physical Health

Individuals with SMI often experience social isolation and loneliness (Lindgren et al., 2014; Linz & Sturm, 2013), which can negatively impact mental health. Research from the United Kingdom indicated that socially isolated people with SMI are more likely to lack insight into their mental illness (White et al., 2000) and to suffer from delusions (Garety et al., 2001). Additionally, smaller social networks were linked to increased levels of positive symptoms (Horan et al., 2006). In investigating the reasons for high rates of psychiatric re-hospitalizations, Mgutshini (2010) found participants attributed their high rates to social isolation and exclusion. An Australian study found that 80.1% of their participants aged 18–34 years with a psychotic disorder felt lonely, and 37.2% identified loneliness as a barrier to recovery (Stain et al., 2012). Social isolation also has deleterious effects on physical health. A meta-analytic review of 148 studies explored the link between social relationships and mortality and found the risks similar to those conveyed by excessive drinking and smoking (Holt-Lunstad et al., 2010). A recent meta-analyses of 70 studies found the health risks of loneliness to be

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comparable to established health risks such as limited access to healthcare, and greater than the risks related to obesity (Holt-Lunstad et al., 2015).

Social Integration

No specific conceptualization of social integration is endorsed by ACT. However, social integration was conceptualized by Ware et al. (2007) as a component of community integration that referred to engagement with social networks that included reciprocal social relationships in non-clinical settings. Social integration was defined as, "A process, unfolding over time, through which individuals who have been psychiatrically disabled increasingly develop and exercise their capacities for connectedness and citizenship" (p. 471). Connectedness included having reciprocal relationships with others with and without SMI. Tsai (2012) described social integration as "emotional or instrumental support clients receive on a non-professional basis from people they interact with in natural social settings, such as support from friends, family members, romantic partners, neighbors, spiritual advisors, landlords, and others" (p. 145).

ACT and Social Integration

Scant research has focused on ACT's efforts to facilitate social integration. An exception was Angell (2003), who asked her participants (ACT clients) about their social relationships. After learning that they had received assistance by ACT workers on social integration endeavors, Angell interviewed two workers who described interventions such as helping ACT clients build relationships between one another, and also between ACT clients and non-mentally ill community volunteers within the context of recreational outings. However, the ACT workers' interventions towards social integration were not studied in depth as only two workers were interviewed. In a Canadian study, Krupa et al. (2005) researched the relationships between ACT workers and clients and found that it was the client/worker bond that facilitated the clients' ability to interact with others; however, they also reported that their participants perceived a lack of sustained effort by ACT to promote community participation and opportunities for social connection. Another Canadian case study (Zimolag & Krupa, 2010) explored pet ownership with only one participant who received ACT services; its findings suggest that pet ownership may support the individual to counterbalance the effects of stigma, serve as a means for the expression of connection, and increase personal and social meaning. In the United Kingdom, Fieldhouse (2012) used participatory research with participants served by assertive outreach to examine the effects of facilitated community participation for individuals who were socially isolated. With the team's intensive support towards engagement with community activities, participants increased their sense of social connectedness. Cognitive Adaptive Training (CAT) was tested with ACT clients in a randomized controlled trial in Denmark without significant results (Hansen et al., 2012). However, a promising approach, Cognitive Behavioral Social Skills (CBSST) has been modified for ACT and is in testing to determine its effectiveness on ACT clients' social functioning (Granholm et al., 2015).

METHOD

Approach

The qualitative research method *Interpretive Description* (Thorne, 2008), was used to explore and describe the experience of ACT team workers surrounding their efforts to facilitate social integration for their clients with SMI. *Interpretive Description* is a qualitative inductive research approach within the naturalistic paradigm (Thorne et al., 1997, 2004). Rich descriptions of socially constructed phenomenon are gathered; meaningful patterns, relationships, and credible new knowledge with relevance to applied practice contexts are discovered (Thorne, 2008). The study was approved by the Institutional Review Board at Seton Hall University, South Orange, New Jersey.

Participants

Participants were solicited from seven ACT teams based out of three agencies from two states within a metropolitan area of the Northeast United States. All of the participants had at least 6 months experience as workers on an ACT team. Gender was reported as 46% male and 54% female. With regard to race, 46% were Caucasian, 42% were African American, 8% were Hispanic, and 4% were Asian American. Sixteen participants were individually interviewed and eight participated in focus groups. As the study progressed, theoretical sampling was used to specifically seek out participants with different types of experience to ensure maximal variation (Thorne, 2008; Thorne et al., 1997). Although most of the participants were enrolled following presentations over a 5 month period, additional participants were invited due to their particular experience. For instance, a psychiatric nurse practitioner was invited to participate for his insight as a prescriber, and a program director was invited due to his global perspective. Out of 24 participants, seven were nurses, and of the 16 individual interviews conducted, six were with nurses. Other disciplines consisted of: three team leaders (master level social workers), two peer counselors, three vocational specialists, two substance abuse specialists, six general case-workers with degrees in social work, counseling, or psychology, and one program director.

Each ACT team served 68–80 clients and was staffed by seven to nine workers. The ACT teams assisted a diverse population in rural, suburban, and urban low income neighborhoods. The clients served lived variably with families, in board and care facilities, independently, and in homeless shelters. All of the clients fit ACT's criteria which were having a diagnosis of SMI, frequent psychiatric hospitalizations, and non-response to traditional outpatient services. Many of the clients served were dually diagnosed with mental illness and substance abuse disorders.

Gaining Access

ACT program directors were contacted and then invitations were given to present the study to three agencies' ACT teams. Letters of solicitation were distributed to the workers and they were given a presentation fully explaining the goals and procedures of the study. Five ACT team workers from the first agency and eleven workers representing three ACT teams from the second agency agreed to participate, signed consent forms, and were interviewed. A third agency was invited to participate in focus group sessions. Letters of solicitation were distributed and a presentation provided. Five members of one ACT team and three members of a second ACT team, each from this agency, signed consents and participated in the focus group sessions. All ACT workers who were willing to participate in the study were included.

Data Collection

The interpretive descriptive approach suggests that collateral methods of data sources be used for triangulation in order to strengthen the analysis of the emerging data (Thorne, 2008; Thorne et al., 1997). This study triangulated using individual interviews, focus groups, and a review of agency documents as data collection methods. Individual interviews elicited the perspectives of individual ACT workers and the focus groups elicited the team perspective. After reviewing the signed informed consents, participants were individually interviewed for approximately 45–90 minutes using a set of open ended questions in an unstructured interview, and two focus groups were conducted using open ended questions in unstructured 60 minute sessions. All interviews and focus groups were audio taped and transcribed verbatim.

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