Wicked Problems and Professional Work:
Disrupting Work in a Mature Field with Incumbent Professions

by

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ABSTRACT

The emerging institutional work perspective implicates agency and action in institutional dynamics in contrast to the traditional organizational institutional approach. In this dissertation, my objective was to explore institutional disrupting work in a mature field with incumbent professions. I developed a two-part case study of the Alberta addictions treatment field. The first part of the case study explored disrupting work at the field level, the second part at the level of professional practice. Data collection included interviews, observations, and documents. My findings show that at the field level and at the level of practice actors' actions were disrupting to institutionalized arrangements and practices of professional work. At the field level, I identified three forms of disrupting work: complexifying work, boundary work, and temporal work. At the practice level, I also identified three forms of disrupting work: configuring work, adapting work, and boundary work. I developed three models of disrupting a field level model, a practice level model, and a multi-level model. My research sheds light on disrupting and how disrupting interrupts the institutionalized arrangements and practices of incumbent professions, both of which, despite scholars' interest in action and agency in institutional life, remain overlooked in empirical research.

Keywords: Institutional Work, Disrupting Action, Institutional Change, Mature Fields, Professions, Professional Practice

DEDICATION

My research is dedicated to my children, Zaria and Nylah, whose curiosity and enthusiasm help me maintain mine. To my husband, Iftikhar, who provided me love, support, encouragement, and critique, as a partner should. To my family, who stood by and helped in any way they could. Research is a solitary endeavour, but happens in a community. Thank you to mine

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CHAPTER 1: INTRODUCTION

I became interested in the topic of institutional change, and in particular institutional work, because my experiences in highly institutionalized healthcare settings did not align with neo-institutional statements presented in the early days of my doctoral studies. Prior to entering doctoral studies I worked as a consultant, exploring with healthcare professionals and managers of healthcare organizations how to modify professionals' institutionalized day-to-day work arrangements and practices in support of new ideas about how to deliver healthcare services. As examples, exploring how to shift care of the elderly away from a medical model and towards a residential model, and exploring how to deliver medical services in a collaborative, integrated way in support of a holistic approach to client care. While it was true that professionals did sometimes resist these explorations, holding fast to traditional ways of working and maintaining institutionalized arrangements and practices, this was not always my experience. Instead, sometimes professionals did change how they were working, in the process sowing the seeds for broader system change. These experiences shaped my interest in the professions, organizations, and institutional change. When I entered doctoral studies, however, I found that my experiences were not well explained by extant theory and empirical research conducted in the tradition of organizational institutionalism.

The imagery of institutions in organizational institutionalism is that they are socially created 'models' that prescribe norms, values, and rules that guide action and behavior in identifiable areas of social life (Meyer and Rowan, 1977; DiMaggio and Powell, 1983). In line with this idea, scholars of organizational institutionalism focused theoretical and empirical attention on explaining the mechanisms and processes through which particular models came to dominate and direct behavior in institutionalized arenas of social life (e.g. Barron et al., 1983; DiMaggio and Powell, 1983; Scott,

1995; Tolbert and Zucker, 1983). In this work, because the assumption was that organizations and actors were passive recipients of institutional models, scholars back-grounded action and agency and focused on macro level theory and empirical research. However, a critique of this approach soon arose, arguing that neo-institutional literature was developing imagery of actors and organizations as being overly constrained by institutions (e.g. DiMaggio, 1988).

This led scholars to develop theoretical statements and empirical studies that aimed to explain change (e.g. Greenwood and Hinings, 1996; Hinings and Greenwood, 1998), strategic action (Oliver, 1991; Seo and Creed, 2002), and creation of new institutional arrangements through institutional entrepreneurship (e.g. Dacin, Goodstein, and Scott, 2002). Change and strategic action perspectives continued to position the institutional environment over actors, suggesting that organizations and actors acted apart from institutionalized models only under particular institutional conditions (Oliver, 1991; Seo and Creed, 2002). Institutional entrepreneurship literature, on the other hand, created an image of 'hypermuscular supermen' (Suddaby, 2010: 15), actors capable resisting environmental institutional pressures and creating new institutional arrangements through targeted action (Dacin et al., 2002). Scholars also started to develop process models of change with some of these implicating action in change processes (see Hargrave and van de Ven, 2006 for review). For examples, the *institutional design model* describes a process through which institutional entrepreneurs create or revise institutional arrangements and the *collective institutional action model* explains the collective and politically oriented action that leads to the construction of new arrangements around new technologies or social movements (Hargrave and van de Ven, 2006: 867-888).

However, while this literature shows that action is starting to find a place in neo institutional theory, much remains to be explored and explained. The focus on change, and in particular

'profound' or field level change (Dacin et al, 2002), means that there remains a void in our understanding of how action is more generally implicated in institutional life. My dissertation endeavors to address this void, stepping away from traditional neo-institutional statements (DiMaggio and Powell, 1983; Meyer and Rowan, 1977) which are rather action less, and instead aligning with the *institutional work* perspective. Scholars interested in this emerging perspective endeavor to develop a more action oriented understanding of modern institutional life (DiMaggio, 1988; Oliver, 1991, 1992) by foregrounding actors' effortful, intentional, and purposive actions that create, maintain, and transform institutions (Lawrence and Suddaby, 2006: 216). At its core, institutional work draws attention to how actors, through action, 'cope with, keep up with, shore down, tear down, tinker with … the institutional structures within which they live, work, and play' (Lawrence and Suddaby, 2006; Lawrence, Suddaby, and Leca, 2009; Lawrence, Suddaby, and Leca, 2011: 53).

In the foundational article on institutional work, Lawrence and Suddaby (2006) drew from extant literature to create a typology of work, describing the following categories of work: creating, maintaining, and disrupting. In their analysis, they showed that creating had received the most attention in part because of its link to institutional entrepreneurship (Dacin et al., 2002; DiMaggio, 1988; Eisenstadt, 1980). They identified that few scholars had empirically examined maintaining work, suggesting that scholars' inattention to this aligned with the assumption that mature institutions simply prescribed actors' behaviors and practices (Lawrence and Suddaby, 2006). Likewise, Lawrence and Suddaby (2006) showed that disrupting work had received little theoretical or empirical attention and that disrupting actions had really only been alluded to in studies of institutional creation and change (e.g. Holm, 1995; Jones, 2001; Leblebici et al., 1991).

Since 2006, a steady stream of institutional work literature has accumulated. Focus on

creating has remained strong (e.g. Cole and Barberá-Tomás, 2014; Hayne and Free, 2014; Ritvala and Kleymann, 2012), but also scholars have started to contribute to an understanding of maintaining (Currie, Lockett, Finn, Martin, and Waring, 2012; Lok and De Rond, 2013; Micelotta and Washington, 2013). A few studies of disrupting work have also emerged (e.g. Bertels, Hoffman, and DeJordy, 2014; Zietsma and Lawrence, 2010). These studies start to draw attention to the importance of disrupting work in the overall process of field transformation (Zietsma and Lawrence, 2010) and to the myriad of actors that engage in action aimed at disrupting institutionalized arenas of modern life (Bertels, Hoffman, and DeJordy, 2014). These latter studies start to draw out the importance disrupting action in deinstitutionalization and start to position actors as the principle agents of institutional dynamics (Hwang and Colyvas, 2011). However, there remains much to be explained in relation to disrupting and institutional life.

Understanding disrupting work is of particular importance in mature fields with incumbent professions. These fields are highly institutionalized and extant literature positions institutional dynamics – i.e. change to professions' arrangements and practices - as actor- and action- less. Research conducted in the traditional neo-institutional traditional, for example, either links dynamics to shifts in the institutional environment (e.g. Kitchener, Kirkpatrick, and Whipp, 2000; Reay and Hinings, 2005; Scott, Ruef, Mendel, and Caronna, 2000) or to spontaneous practice variation and diffusion (e.g. Lounsbury and Crumley, 2007; Smets, Morris, and Greenwood, 2012). Indeed, when purposeful disrupting action is examined in these fields research has shown that incumbent professions neutralize this action at both the field level (Currie, Lockett, Finn, Martin, and Waring, 2012; Micelotta and Washington, 2013) and the level of practice (Kellogg, 2012) in process maintaining traditional institutionalized arrangements and practices. This motivates a number of theoretical and practical questions about mature fields with incumbent professions. For

example, if the day-to-day work of incumbent professions maintains and strengthens institutions, how can institutionalized arrangements and practices be purposefully changed? Are there particular actors who are more or less able to affect institutional dynamics in these fields? Are there particular actions that are more or less influential in these fields? What can we learn about agency and action by examining these fields?

My goal in this dissertation is to explore disrupting work in a mature field with incumbent professions and to examine connections between disrupting work at different levels. The research setting is the Alberta addiction treatment field, a 'real-life, contemporary context' (Creswell, 2013: 97) in which disrupting actions are being undertaken to address the wicked problem (Rittel and Weber, 1973) of addiction (Hannigan and Coffey, 2011; Head, 2008). My research consists of a case study, conducted in two parts. Part 1 examines the disrupting work undertaken by field level actors (e.g. policy makers, organizational decision makers, and members of a pro-active private foundation). In this study I ask, *how do actors disrupt a mature field with incumbent professions?* Part 2 examines the action of professionals and managers actively disrupting traditional professional practice. In Part 2 I ask: *how do actors disrupt professional practice?*

The outline of my dissertation is as follows. The introduction, presented in Chapter 1, briefly describes the motivation for my research and presents guiding research questions. In Chapter 2, I present a review of the institutional work literature, drawing attention to the ongoing void that remains with respect to disrupting. In this chapter, I draw on literature that shows that mature fields with incumbent professions are particularity resistant to disrupting. I also describe the importance of understanding effective disrupting action in these fields, focusing on the potential of disrupting action to alter institutionalized arrangements and practices so that incumbent professions can work more creatively and collectively on wicked problems. I conclude Chapter 2 by presenting the

research questions that guide my case study. In Chapter 3, I describe the research setting, the research design, data collection methods, and approach to data analysis. In Chapter 4, I present the findings of my case study. In Chapter 4, Part 1, I present the findings from the field study of disrupting work. In Chapter 4, Part 2, I present the findings from the micro study of disrupting professional practice. In Chapter 5, I provide a discussion that brings the two parts of the case study together and I outline contributions of this research. In Chapter 6, I present conclusions, limitations and suggestions for future research. References and appendices follow the chapters.

CHAPTER 2: THEORETICAL BACKGROUND

The theoretical background focuses first on the concept of institutional work. I review empirical literature on institutional work by level of analysis, identifying that at all levels of analysis *disrupting work* remains overlooked. I next draw attention to mature fields with professions as incumbents arguing that these fields are particularly resistant to disrupting work, and supporting this position with empirical research from three separate traditions (neo-institutional theory, sociological literature on the professions, and literature on interprofessional collaboration). Finally, I bring in the concept of wicked problems. Today's wicked problems require disrupting action in mature fields with incumbent professions because resolving wicked problems will require professions and professionals to work with different arrangements and practice. I conclude with research questions and an overview of my research setting.

Institutional Work

The traditional focus of neo-institutional organizational studies has been to explain how institutions, those more or less 'enduring elements of social life' (Hughes, 1936) shape the behavior of social actors by providing templates for action (DiMaggio and Powell, 1991; Meyer and Rowan, 1977; Scott, 1995, 2001). Within this tradition, the overriding assumption has been that actors' action rather unconsciously conforms to institutionalized templates. Following, institutional scholars have a long history of focusing attention on macro level stability and change in the process downplaying agentic action – action that diverges from institutionalized templates – and reifying institutions control over social life (DiMaggio, 1988; also see Lawrence and Suddaby, 2006, for review).

Although mostly overlooked, early neo-institutional statements did however implicate agency and action in institutional life (DiMaggio, 1988). DiMaggio, for example, asserted that 'new

institutions arise when organized actors with sufficient resources see in them an opportunity to realize interests that they value highly' (1988: p. 14). This idea was subsequently incorporated into research on institutional entrepreneurship, a line of research that explores actions through which actors incorporate interests and goals into the institutions they create (e.g. Garud, Hardy, and Maguire, 2007; Garud, Jian, and Kumaraswamy, 2002). Oliver (1991) also pointed to strategic agency in institutional environments, theorizing the different ways that organizations might respond to institutional pressures. It was also incorporated into research on strategic action in institutional environments (Oliver, 1991), from which developed a line of scholarship that focused on exploring organizations' end responses to institutional pressures but in which action still remained under explored and under theorized (Lawrence and Suddaby, 2006).

In contrast, contemporary thinking about *institutional work* broadens the scope for investigating action in institutional life (Lawrence and Suddaby, 2006; Lawrence et al., 2009, 2011). Aligned with an understanding that institutions arise *from* human action (Jepperson, 1991) institutional work positions action as a central element in explaining institutional dynamics – the maintaining, disrupting, and creating of institutions (Lawrence and Suddaby, 2006; Lawrence et al., 2009, 2011). The concept provides an umbrella under which institutional scholars can legitimately set aside the traditional institutional question, how do institutions shape (and constrain) action, for a different question, how does action connect to institutions? The goal of scholars interested in the institutional work perspective is to, thus, explore how actors 'cope with, keep up with, shore down, tear down, tinker with, transform, or create anew the institutional structures within which they live, work, and play' through action (Lawrence et al., 2011: 53).

Institutional work's focus on action encourages scholars to pay attention to the motivations, interests, and efforts that underpin action (Lawrence et al., 2009: 8). In this perspective, research

should not be limited to studies of strategic action (e.g. Oliver, 1991), entrepreneurial action (e.g. Garud, Hardy, and Maguire, 2007), or action that arises because of institutional conditions or contradictions (e.g. Seo and Creed, 2002; Thornton, Ocasio, and Lounsbury, 2012). Instead, empirical studies should draw attention to the myriad of actions undertaken with purpose and intent that link to maintaining, disrupting, or creating institutions, even when the institutional effect of these actions is unclear (Lawrence et al., 2009: 11).

Putting action first is an important enlargement for studies of organizational institutionalism. Focusing on institutional work presents an opportunity for scholars to develop new understandings of how action and agency are implicated in modern institutional life (Lawrence et al., 2009). It also presents an opportunity for scholars to develop more nuanced models of institutional dynamics than are available currently (e.g. Greenwood and Hinings, 1996; Hargrave and van de Ven, 2006; Greenwood, Raynard, Kodeih, Micelotta, and Lounsbury, 2011; Thornton, Ocasio, and Lounsbury, 2012). As Lawrence et al. state, action 'may create institutions, but it might also fail to do so; it might affect institutions in unintended ways, including disrupting those institutions or creating ones very different from those originally conceived of by the actors involved' (2009: 11).

In their introductory article, Lawrence and Suddaby (2006) described three categories of institutional work – creating, maintaining, and disrupting. The first, *creating work,* speaks to how new institutions and institutional arrangements come to be. Creating includes actions such as 'defining rule systems and vesting them with the ability to confer property rights; constructing normative networks of actors possessing defined identities in relation to the new rule systems; and, developing support for those rule systems through advocacy, theorizing, and educating' (Lawrence and Suddaby, 2006: 221). The second category, *maintaining work*, describes the purposeful and effortful actions through which actors maintain the integrity of existing institutions. Maintaining

actions include enabling, which shores up existing institutions; policing, which ensures compliance with rules; deterring, valorizing and demonizing, which establish barriers to institutional change; mythologizing, which preserves the normative underpinnings of institutions; and, embedding and routinizing, which embeds the normative foundations of institutions into day-to-day routines and practices (Lawrence and Suddaby, 2006: 230). The third category, *disrupting* work focuses attention on the actions of individuals whose 'interests are not served by existing institutional arrangements, and who will consequently work when possible to disrupt the extant set of institutions' (Lawrence and Suddaby, 2006: 235). Disrupting action includes disconnecting sanctions from practices, technologies or rules; dissociating moral foundations of practices, technologies or rules within particular cultural contexts; and undermining assumptions and beliefs to decrease the perceived risks of innovation (Lawrence and Suddaby, 2006: 235).

In relation to the three forms institutional work, Lawrence and Suddaby (2006) identified that creating work had received the most attention and that scholars had overlooked maintaining work and disrupting work.

Empirical Studies of Institutional Work

In recent years, a steady stream of empirical research has emerged exploring institutional work at the field level (e.g. Currie et al., 2012; Micelotta and Washington, 2013; Zietsma and Lawrence, 2010; Zietsma and McKnight, 2009); at the organizational level (Gawer and Phillips, 2013; Rojas, 2010); at the group level (e.g. Empson, Cleaver, and Allen, 2013); and at the micro- and level (e.g. Creed, DeJordy, and Lok, 2010; Lok, 2010; Lok and De Rond, 2013). A few studies have also attempted to connections levels of analysis (e.g. Dacin, Munir, and Tracey, 2010; Leung, Zietsma, and Peredo, 2014).

Field studies of institutional work

Fields are identifiable 'sets of organizations that, in the aggregate, constitute a recognized area of institutional life' (DiMaggio and Powell, 1983: 148-149). Scholars bound fields in different ways. DiMaggio and Powell aggregated organizations similar in 'products, markets or industries' (1983: 143). Scott looked to the 'community of organizations' that forms when organizations 'partake in a common meaning [system] and … interact more frequently and fatefully with one another than with actors outside the field' (1995: 56). Finally, Hoffman (1999) argued that fields form around issues around which actors and organizations stake claims in support of their interests. These fields mature as a common understanding of the issue develops and as actors' positions relative to the issue and relative to one another are solidified (Hoffman, 1999). Each of these ways of bounding fields has proven fruitful for neo-institutional scholars who explore how exogenous institutional pressures (e.g. Scott, 1995) and logics (e.g. Friedland and Alford, 1991) shape the behavior of field members. Scholars interested in institutional work maintain a focus on fields. They, however, ask how agency and action of field members is implicated in creating, maintaining, and disrupting field institutions.

Emphasis on creating remains strong in these studies, with scholars examining the actions that create new fields (Cole and Barberá-Tomás, 2014; Hayne and Free, 2014; Ritvala and Kleymann, 2012; Zietsma and McKnight, 2009) and the actions that distribute new practices through new fields (Hayne and Free, 2014). Cole and Barberá-Tomás (2014), for example, described the actions of an association – a field level institutional entrepreneur – that transferred knowledge across social and institutional contexts, bridging networks and creating common conventions of actions and through this creating a new field, the European Animation Industry. Ritvala and Kleymann (2012) showed that the creating of functional foods cluster in Finland was associated with four kinds of creating action, ideational, material, bridging, and authentic leadership. Hayne and Free (2014) described the

theorizing, rhetorical appeal, mythologizing, constructing, and educating actions undertaken by a hybridized professional services firm to advocate and promote the use of a new practice in the emerging field of risk management. Finally, Zietsma and McKnight (2009) explored the institutional work implicated in creating proto-institutions in an emerging field.

Another stream of research focuses on change in mature fields (Chiwamit, Modell, and Yang, 2014; Jones and Massa, 2013; Zietsma and Lawrence, 2010). In these studies, scholars have examined how novel practices become legitimate in mature fields (Jones and Massa, 2013). They also have explored actions within the different phases of mature field transformation, drawing attention to the importance of boundary work and practice work by field incumbents and external actors during each stage (Zietsma and Lawrence, 2010). Zietsma and Lawrence (2010) showed that challengers' boundary and practice disrupting work was met with incumbents' boundary and practice bolstering work that served to shore up existing boundaries and defended existing practices. Ultimately, another actor - institutional entrepreneurs – purposeful boundary and practice work broke up the stalemate between incumbents and challengers, setting the course for field transformation. This insightful study shows clearly how the action of a collective of actors is implicated in institutional dynamics, sometimes maintaining, sometimes challenging, and sometimes altering extant institutions. Finally, Chiwamit, Modell, and Yang (2014) showed how different field conditions contributed to the evolution of institutional work in two mature fields, the fields of Chinese and Thai state-owned enterprises, drawing attention to the need to understand institutional work in relation to the contexts of individual fields.

A few studies pay particular attention to maintaining work in mature fields (Currie et al., 2012; Micelotta and Washington, 2013). Both Currie et al. (2012) and Micelotta and Washington (2013) examined the maintaining work of professions in mature fields undertaken in response to

disrupting actions of state actors. These studies show that professions' maintaining work not only neutralized the disrupting actions of state actors but also strengthened and reinforced traditional arrangements and roles (Currie et al., 2012; Micelotta and Washington, 2013).

Studies of disrupting work at the field level remain scarce with studies continuing to point to disrupting, while not studying it explicitly. Some studies, such as Micelotta and Washington (2013) and Currie et al. (2012), hint that incumbents engage in maintaining actions in response to heavy-handed disrupting action, but exclude analysis of the latter in order to focus on the former. Possibly the study that comes closest to studying disrupting is Bertels and colleagues' (2014) study of the U.S. environmental movement. In this study, Bertels and colleagues identified the various roles challengers adopted and described challengers' indirect and direct challenging work that was aimed at altering long held notions and practices of corporate environmentalism. Bertels et al. suggested that challenging work may be 'an important moderator to the effectiveness of direct forms of institutional work', including disrupting (2014: 1173).

Some general insights can be drawn from field studies of institutional work. First, field studies of institutional work suggest that the original typology of work created by Lawrence and Suddaby (2006) may be overly simplistic. Scholars are identifying new forms of work including repair work (Micelotta and Lawrence, 2013) and evangelism work and adaptive emulation work (Jones and Massa, 2013). They are showing how identified forms of work, including boundary work and practice work, differ along the institutional life cycle (Zietsma and Lawrence, 2010). Scholars are also uncovering the interactions and interconnections between different kinds of work (e.g. Zietsma and Lawrence, 2010).

Second, these studies continue to focus on work that has known institutional effects or work that has resulted in an observable institutional outcome (Lawrence and Suddaby, 2006). Studies of

new and emerging fields draw attention to creating work (e.g. Cole and Barberá-Tomás, 2014). Studies of transformed mature fields attend to the work involved in achieving transformation and reinstituting new institutions (Zietsma and Lawrence, 2010; Zietsma and McKnight, 2009). Studies of mature fields attend to the maintaining work that neutralizes disruptions and that maintains the traditional institutional characters of the fields (e.g. Micelotta and Washington, 2013). Attending to work that has resulted in an observable effect may be one reasons that, for the most part, disrupting work remains under examined and theorized in field level studies.

Third, field studies foreground the collective and temporal nature of institutional work, pointing to the heterogeneous collectives of actors that engage in institutional work over extended periods of time (e.g. Jones and Massa, 2013; Zietsma and Lawrence, 2010; Zietsma and McKnight, 2009). Zietsma and Lawrence (2010) and Zietsma and McKnight (2009), for example, show how developing new boundaries and practices required concurrent work from different social actors, some incumbent some external to the field. This collective institutional work is undertaken over a number of years, even generations (Jones and Massa, 2013; Zietsma and Lawrence, 2010).

Forth, a few studies describe the intentionally and effort underpinning institutional work (e.g. Bertels et al., 2014; Jones and Massa, 2013) and the creative ways that actors use action to affect institutions (e.g. Currie et al., 2012). Some forms of institutional work seems linked to actors' intent to pursue alternate futures (e.g. Bertels et al., 2014; Jones and Massa, 2013; Zietsma and Lawrence, 2010). Jones and Massa (2013), for example, described the purposeful and intentional actions of prophets, who offered an alternate future; evangelists, who 'spread the novel practice; truth tellers, who 'consecrate[d] the novel practice as an exemplar'; and, shepherds, who 'protect[ed] the novel practice so that it survive[d]' (Jones and Massa, 2013: 1115). In contrast, Currie et al. (2012) drew attention to the creative work of incumbent professions who used theorizing and defining action,

typically ascribed to creating, to maintain institutional arrangements, sustaining a future where professional dominance was upheld.

Micro studies of institutional work

Scholars interested in microfoundations of institutions (Powell and Colyvas, 2008) and interested in developing agentic accounts of institutional dynamics (Hwang and Colyvas, 2011) have also contributed to developing the institutional work literature. Scholars have explored how action maintains extant institutions (e.g. Bjerregaard and Jonasson, 2014; Dacin et al., 2010; Lok and De Rond, 2013). They have also explored action when environmental conditions change and challenge institutionalized arrangements and identities (Empson et al., 2013; Lok, 2010). They have also explored settings where actors' experience a mismatch between individual and institutionalized identities and roles (e.g. Creed et al, 2010; Leung, et al., 2014).

Micro-level studies of institutional work also suggest that the original typology provided by Lawrence and Suddaby (2006) may not adequately reflect the range and nuances of action classifiable as institutional work. Similar to field studies, micro-studies of institutional work are identifying previously unrecognized forms of action including embodied identity work (Creed et al., 2010), emergent (internal and external) identity work (Leung et al., 2014) and containment work and restoration work (Lok and De Rond, 2013). Studies are also showing that actors engage in multiple types of action simultaneously (e.g. Empson et al., 2013; Leung et al., 2014; Lok and De Rond, 2013). Empson (2013) identifies seven forms of institutional work that actors in a new partnership dyad engage in that simultaneously have the effect of creating, maintaining, and disrupting the institutionalized notion of a partnership.

In micro level research, identity work features heavily (Creed et al., 2010; Leung et al., 2013; Lok, 2010) and highlights the often complex relationship between institutional action and

institutional effects. Creed et al. (2010) showed how GLBT ministers purposefully and intentionally undertook embodied identity work creating through this an identity that supported new rules, norms, and beliefs about who could hold the role of protestant minister. At the same time, this identity work maintained and preserved traditional values about the church as an institution and the work of its ministers. Lok (2010), in an examination of the introduction of a new logic in the United Kingdom financial management field, showed how the identity work of institutional investors and financial managers sometimes changed identity so that actors could comfortably enact new practices that aligned with the new logic. He also showed that some identity work changed identity in a way that legitimized the enactment of traditional practice, in particular practice that sustained professional autonomy, a value of central importance to the professions (Kraatz & Zajac, 1996; Marquis & Lounsbury, 2007; Scott et al., 2000) but that was contrary to the new logic. Finally, Leung et al. (2014), in an examination of Japanese housewives, showed that emergent identity work changed institutionalized role boundaries even as it maintained the institutionalized belief that Japanese housewives were familial caretakers concerned with traditional values of health and wellbeing. These studies show that institutional work at micro levels can have multiple – and some unintended - effects.

In micro-level research, work arrangements and practices feature prominently. Some studies focus on explaining how action maintains arrangements and practices (Bjerregaard and Nielsen, 2010; Dacin et al., 2010; Lok and De Rond, 2013). Bjerregaard and Nielsen (2010) showed how actors' conformance to a bureaucratic organizational arrangement maintained institutional authority and power. Dacin et al (2010) showed how the enactment of a ritual dining routine at an elite university maintained social roles at the micro level and maintained the broader class structure in the United Kingdom. Lok and De Rond (2013) examined how micro level practices are maintained

through day-to-day action. Examining regular disruptions in the enactment of the Cambridge Boat Race, Lok and De Rond (2013) described how normalizing actions (ignoring and excepting or co-opting disruptions), negotiating actions (tolerating and reversing disruptions) and custodial actions (self-correcting and formally disciplining when disruptions were experienced) maintained practice. In this setting, actors' containment work temporarily patched up disruptions and actors' restoring work re-framed disruptions as 'necessary exceptions', ultimately maintaining institutionalized practice and making it resilient to minor and major breakdowns (Lok and De Rond, 2013: 186).

Micro studies of institutional work show the collective nature of institutional work (e.g. Empson et al., 2013; Leung et al., 2014; Lok and De Rond, 2013). In Empson et al.'s (2013) study, the interactions between professionals in a new partnership arrangement both shaped the new arrangement and maintained traditional professional roles. Similarly, Lok and De Rond (2013) showed that practice maintenance was achieved through the collective interactions and negotiations that took place between rowing team members and coaches. Finally, Leung et al. (2014) showed how Japanese housewives' identity and role boundary work was both an individual accomplishment and an accomplishment achieved through the collective action of the wives' food co-operative.

Again, like in macro-studies, a few micro-studies speak to effort and intentionally in relation to institutional work. While some studies illustrate how actors' actions rather unintentionally maintain institutionalized practices and broader institutions (e.g. Dacin et al., 2010; Lok and De Rond, 2013), other studies point to the motivation and intent that underpins institutional action (e.g. Creed et al., 2010; Lok, 2010). Creed et al. (2010) suggested that emotion and the desire for authenticity underpinned the embodied identity work of GLBT ministers. Lok (2010) suggested that identity work is a form of resistance against field level attempts to affect identity and practice change. It is surprising, however, that more attention has not been paid to effort and intentionally in

micro level studies as the motivations and interests of actors undertaking work at this level should be readily visible.

Finally, and again similar to field level research, there continues to be a distinct lack of attention on disrupting action at the micro level.

Meso (organizational) studies of institutional work

Some empirical work has been concerned with institutional work done in and by organizations (Gawer and Phillips, 2013; Rojas, 2010). In their examination of Intel managers' purposeful institutional work, Gawer and Phillips (2013) described action aimed at changing the logic and practices of the computer industry (external work), and changing organizational identity and practices (internal work). Practice and identity work was complementary, with internal identity work supporting the creation of new internal practices and external identity work supporting the legitimation of new practices in the field (Gawer and Phillips, 2013). Gawer and Phillips (2013) draw attention to organizational managers as agents of institutional work, identifying that managers' action can have both internal and external institutional effects and that managers' institutional work involves addressing tensions that arise as identity and practices are changing (Gawer and Phillips, 2013: 1037). Rojas (2010) conducted an institutional work study at the meso-level describing how an actor in a position of organizational authority can leverage symbolic resources into coercive resources, which can then be applied to achieve institutional change. In his study of the 1968 Third World Strike at San Francisco State College, Rojas (2010) showed how a college president was able to, through institutional work, increase his authority and power and change rules of student conduct and dispute resolution. While these studies position organizational actors as doers of institutional work, much remains to be understood about organizational actors' institutional work. For example, it is not clear whether field context affects which organizational

actors will engage in institutional work, the nature and characteristics of their institutional work, or its intended and unintended effects.

Disrupting Work A Persistent Void

While the burgeoning institutional work literature is drawing attention to action in fields, a substantial void remains in relation to understanding disrupting work. When the concept of institutional work was originally conceived, Lawrence and Suddaby stated that few 'concrete descriptions' of agentic disrupting action were available (2006: 235). My review of the institutional work literature since that time shows that this conclusion continues to ring true. Field studies of institutional work remain focused on actors' maintaining and creating work implicated in observable institutional effects. With a few exceptions (e.g. Zietsma and Lawrence, 2010), disrupting work has been neglected. This might be because disrupting work is masked by creating and maintaining work. However, it might also be because scholars assume that actors disrupting work is temporary and only tangentially important in field dynamics. If it is the latter, this continues to perpetrate the rather dichotomous problematization of actors in institutional theory (Hwang and Colyvas, 2011). Indeed, focusing on actors' actions that either create or maintain institutions continues to present a polarized image of actors as either being heroic (i.e. creating new institutions) or rather institutionally constrained, simply maintaining what is already in place (Hwang and Colyvas, 2011; Lawrence and Suddaby, 2006). On the other hand, disrupting work has the potential to shed light on how some actors become skillful in reflecting on existing institutional conditions and in engaging in action aimed at affecting extant institutions (Fligstein, 2001; Hwang and Colyvas, 2011; Powell and Colyvas, 2008)

Disrupting Work in Mature Fields with Incumbent Professions

Actors' disrupting work may not be equally important in all fields. Indeed, in some fields it

may represent a type of action that can be glossed over without affecting explanations of field dynamics. However, in other fields understanding actors disrupting work is critical to understanding institutional dynamics, for example dynamics in mature fields with incumbent professions. Mature fields with incumbent professions are constituted around important societal issues and the work of incumbent professions is to solve fields' issues, or those 'problems amenable to expert services' (Abbott, 1988: 35) that reflect 'core societal values … health, justice, financial status' (Leitch and Fennell, 2008: 431). In these fields, including healthcare (Kitchener, Kirkpatrick, and Whipp, 2000; Reay and Hinings, 2005; Scott et al., 2000), accounting (Greenwood et al., 2002), public services (Kirkpatrick, Ackroyd, and Walker, 2005), and modern day publishing (Thornton, 2002), incumbent professions hold substantial power and influence.

In mature fields with incumbent professions known forms of disrupting action – e.g. disconnecting sanctions and dissociating moral foundations of practices, technologies, or rules and undermining assumptions and beliefs (Lawrence and Suddaby, 2006: 235) - are unlikely to be disruptive. Indeed, extant research suggests that incumbent professions will respond to these kinds of disrupting actions with maintaining work that will neutralizes disrupting action at the field level (e.g. Currie et al. 2012; Micelotta and Washington, 2013) and that will restore traditional practices at the micro level (Kellogg, 2012). These ideas are summarized in Table 1: *Disrupting work and reactions to disrupting work in mature fields with incumbent professions.* If this is the case, how are these mature fields intentionally disrupted? Does disruption happen only when heroic actors enter the field and engage in action that counters the power and authority of incumbent professions? Or, does disrupting happen only when incumbent professions themselves overcome the blinders and ties that hold their action to that which is institutionally prescribed? Or, does disrupting happen through some other kinds of action?

	Level of Analysis	
	Field Level	**Practice Level**
Disrupting Work	Disrupting includes: **disconnecting sanctions** and **dissociating moral foundations** of practices, tech, or rules; **Undermining assumptions and beliefs** (Lawrence and Suddaby, 2006: 235)	Practices are disrupted through regular variation in practice (work), and become **plastic and resistant to these disruptions** (Lok & De Rond, 2013)
Incumbent Professions ***Reactions to Disrupting Work***	**Professions neutralize disruptions** to roles and arrangements with maintenance work (Currie et al., 2012; Micelotta & Washington, 2013)	**Professions sustain purposefully disrupted practices** through countertactics (Kellogg, 2012)

Table 1: Disrupting work and reactions to disrupting work by incumbent professions.

Institutional and sociological perspectives

Institutional literature shows that mature fields with professions as incumbents are organized around particular values, norms, and beliefs including personal expertise, personal quality of craft, and professional autonomy (e.g. Kitchener et al., 2000; Reay and Hinings 2005; Scott et al. 2000; Thornton, 2002; Thornton et al., 2012). At the field level efforts made to disrupt these values and beliefs are met with resistance, and change, if it happens at all, is slow (e.g. Kirkpatrick et al., 2005; Kitchener et al., 2000, Reay and Hinings 2005; Scott et al., 2000). The institutional work maintenance literature supports these findings as it shows how professions' maintaining actions neutralize the disrupting actions of other actors, in particular disrupting that targets arrangements and roles (e.g. Currie et al., 2012). Also at the micro-practice level, intentional efforts to disrupt and change professional practice are resisted. Kellogg's (2012) insightful study of practice disruption in a healthcare surgery setting showed how defenders of traditional professional practice maintained practice in the face of an active attempt to reform (disrupt) it. Defenders used 'status-based countertactics' to divide reform coalitions and re-integrate reformers into defenders of traditional practice (Kellogg, 2012). This subtle and creative maintenance work in the face of purposeful attempts to disrupt professional practice speaks to the very real challenge of disrupting professions'

institutionalized practices.

Overall, institutional scholarship does not provide much insight into actor led disrupting of mature fields with incumbent professions. Instead, theoretical and empirical literature suggests that new practices arise as anomalies from regular practice variation (Lounsbury and Crumley, 2007; Smets et al., 2012) and not through targeted, intentional disrupting of traditional practices.

Sociological literature on the professions also provides insights to the challenge of disrupting mature fields with incumbent professions. In these fields, professions' power comes from a socially legitimated mission that grants professions an exclusive right to apply expert knowledge to particular problems (Abbott, 1988; Freidson, 2001). This has allowed professions to retain substantial control over the organization and practices of their work. The hierarchical organization of professional work reflects negotiated macro settlements created to resolve inter-professional competitions over jurisdiction (Abbott, 1988). The hierarchy provides interaction rules for related professions, and jurisdictional boundaries provide space within which related professions autonomously and independently apply problem-solving models and tools. This division of labor forms the 'essential cultural logic of professional practice' (Abbott, 1988: 40).

The professions' division of labor impedes attempts to actively spread new practices in these fields, as Ferlie, Fitzgerald, Wood, and Hawkins (2005) showed in the context of the non-spread of a new practice concerned with standardizing professional work. The division of labor has also been implicated as a factor in institutional maintenance in reaction to active attempts to disrupt these fields (e.g. Currie et al., 2012). At micro levels (i.e. professional practice) research has shown that professionals' day-to-day action protects and maintains boundaries between different professions even when these are not actively challenged (e.g. Bechky, 2003). In light of this, active attempts to disrupt professional practice are likely to be resisted. Ultimately, sociological literature also

suggests that intentional attempts to disrupt the micro practices and arrangements of professional work will largely be unsuccessful.

Studies of interprofessional collaboration

Finally, practitioner oriented empirical examinations of professionals in organizations shed light on what happens in the face of intentional disrupting action. In healthcare a developed literature exists on inter-professional collaborations (IPCs), new work arrangements for professionals in which collaborative, cross-jurisdictional, shared practice is encouraged as a disruption to hierarchical, independent, boundaried practice (D'Amour, Ferrada-Videla, San Martin Rodriguez, and Beaulieu, 2005; Petri, 2010). IPC research shows that when traditional practice is disrupted by IPCs professionals strongly resist and maintain traditional roles and interactions (Barrett, Curran, Glynn and Godwin, 2007; Mitchell, Parker and Giles, 2011; Thornhill, Dault and Clements, 2008). Friction, hostility, low knowledge sharing, unequal participation, and cultural barriers have be identified in IPC work arrangements (Atwal and Caldwell, 2005; Brown, Lewis, Ellis, Stewart, Freeman, and Kasperski, 2011; Caldwell and Atwall, 2003; Hall, 2005), with all contributing to the maintenance of traditional practice.

Wicked Problems and Disrupting Mature Fields with Incumbent Professions

Intentionally disrupting arrangements and practices in mature fields with incumbent professions is exceedingly difficult. Institutional work literature (Currie et al., 2013; Micelotta and Washington, 2013) is starting to uncover how professions' maintaining work neutralizes and reverses targeted attempts to disrupt arrangements in fields. Sociological studies highlight how the division of expert labor shapes the arrangements and practices of professionals, and shows that professionals resist active attempts to disrupt these (e.g. Ferlie et al., 2005; Kellogg, 2012). Finally, interprofessional collaboration literature highlights the many challenges and barriers experienced

when intentional disrupting actions are taken in organizations and new work arrangements implemented. However, there are situations where the intentional disrupting of mature fields with incumbent professions is called for.

Today, despite professions' best efforts, many important social problems persist. Indeed, truly 'wicked problems' (Churchman, 1967; Rittel and Webber, 1973) such as poverty, climate change and health (Hertel and Rosch, 2010; Kreuter, De Rosa, Howze, and Baldwin, 2004) are particularly immune to professions traditional ways of working. Wicked problems (Conklin, 2006; Rayner, 2006; Rittel and Webber, 1973) exist within and between social sectors, they have no definitive formulation or solution and are not solvable through linear planning or by applying specialized causal models and tools, the professions traditional way of solving problems. Because wicked problems are multi-sectoral, solutions necessarily involve many stakeholders (Rittel and Webber, 1973), an approach that runs counter to ideas such as of professional independence and autonomy.

More creative and innovative approaches are needed to resolve wicked problems (Conklin, 2006; Rayner, 2006; Rittel & Webber, 1973). In fields where wicked problems constitute the field's issue there has been a push to move towards networked and collaborative arrangements (Ferlie, Fitzgerald, McGivern, Dopson, and Bennett, 2013; Zimmerman, 2010). There have also been calls to implement collaborative work arrangements for professionals and to develop practice that is more collaborative (Abele, 2011; Adler, Kwon, and Heckscher, 2008; Conklin, 2006). These calls are underpinned by the assumption that collaboration will create conditions in which 'the creativity and resourcefulness of a group or team' can be exposed and used to develop new solutions (Conklin, 2006: 2).

In the face of evidence that shows that actively disrupting professions' arrangements and practices will be difficult, and that disrupting actions will be neutralized by incumbent professions

(e.g. Currie et al., 2012; Kellogg, 2012; Micelotta and Washington, 2013), I wondered how can a mature field with incumbent professions be intentionally disrupted? My goal in this dissertation is thus to *explore disrupting work in a mature field with incumbent professions*. Understanding that disrupting work is likely to be undertaken at field and micro levels, I conducted a case study in two-parts. The research setting is the Alberta addictions treatment field. In this mature field, arrangements and practices of incumbent professions are being disrupted as the understanding of addiction shifts from an individual behavioral-choice problem to a wicked problem. The field study (Part 1) examined the actions taken to disrupt the field, addressing the question, *how do actors disrupt a mature field with incumbent professions?* The micro study (Part 2) examined the actions of professionals and managers whose aim was to disrupt traditional addiction treatment practice and make it more integrated and collaborative. In this study, I explored the question, *how do actors disrupt institutionalized professional practice?*

CHAPTER 3: RESEARCH SETTING AND METHODS

In this chapter, I describe the research setting and research methods used to explore disrupting work in a mature field with incumbent professions. I start by describing the research setting – the Alberta addictions treatment field. In this, I describe two levels. First, the field level, where policy makers, government representatives, and decision makers in a variety of organizations are engaging in disrupting action. Second, the micro level, or the level of professional practice where professionals provide services to individuals with addiction problems. At this level, managers and professionals are taking action to disrupt professional practice. After describing the research setting, I shift into a discussion of research methods, describing the research design, data collection approach, and approach to data analysis.

Research Setting: The Alberta Addictions Treatment Field

The *Alberta addiction treatment field* is a mature field formed around the issue of addiction. In the field, addiction is understood in a particular way legitimizing particular treatment approaches, one of which has long been the domain of professionals. Today, however, actors who envision a different future for addiction treatment are disrupting the field, making this an excellent setting in which to explore disrupting work. *Figure 1: Current and alternate future state of addictions treatment in Alberta,* provides a summary of the field's current state and alternate future state as envisioned by actors engaged in disrupting work. Research questions are included for reference, and I describe the figure in more detail on the following pages.

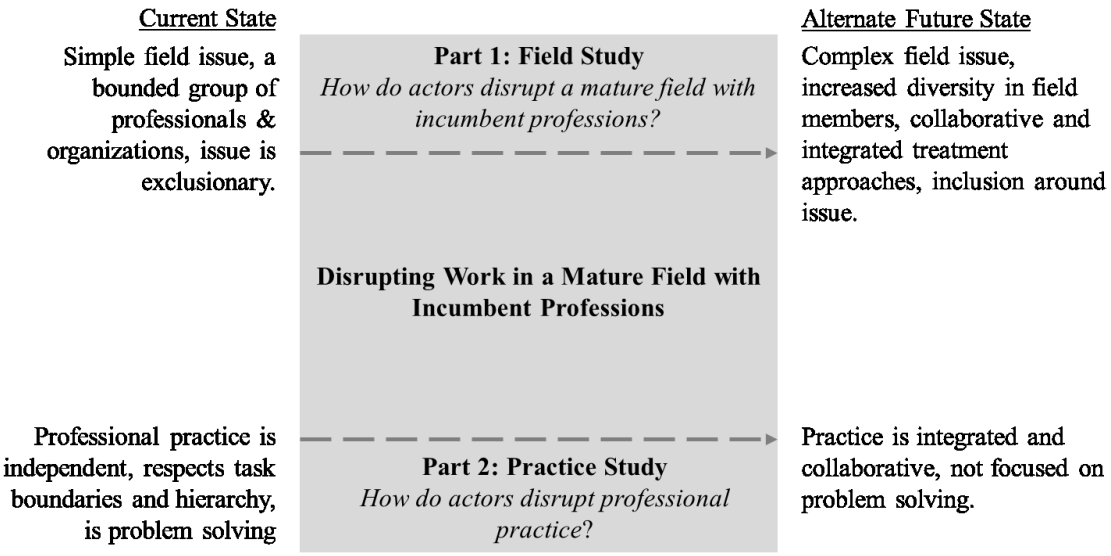

Figure 1: Current and alternate future state of addictions treatment in Alberta.

There are many different ways to understand addiction, but one common understanding is that addiction is 'an irrational need that takes place in the individual' arising from 'an individual's loss of control over behaviors' (FrameWorks, 2010: 6). In line with this understanding, an addict is expected to change behavior to 'acknowledge his or her problem, take greater responsibility and assert willpower' (FrameWorks, 2010: 6), ultimately abstaining from using drugs or alcohol. In Alberta, this understanding and approach to treating addiction underpinns two treatment approaches, a 'non-professional' approach and a 'professional' approach. The former includes self-help and peer-support groups such as Alcoholics Anonymous and similar programs that apply a 12-step approach and that draw heavily on peer support and advice from individuals with 'lived experience'. The latter, the professional approach, centers around treatment and counselling by psychologists, social workers, and addiction counsellors in private practice (i.e. private offices), residential treatment centers, and AADAC (the Alberta Alcohol and Drug Abuse Commission) an arms-length government organization that employs these professions and that provides community based and residential treatment for addiction.

Professional addiction treatment is focused on the provision of *behavioral therapy and counselling* (Burke, Arkowitz, and Menchola, 2003; Hettema, Steele, and Miller, 2005). This approach engages 'clients in discussion about … aspects of their lives to facilitate recovery from alcohol [and] other drug … problems' (AADAC, 2006a). Psychologists, social workers, and addiction counsellors typically employ *motivational interviewing* and *stages-of-change* therapy and tools helping clients explore and resolve ambivalence to change with the aim of eliciting behavioral change. Using motivational interviewing professionals help clients develop an understanding of the 'discrepancy between … [their] values and behaviors', help support 'client self-efficacy about changing', and help explore and shift 'client ambivalence [by] eliciting and reinforcing client change talk' (Miller & Rollnick, 2009). In addition, registered professionals including psychologists and social workers also provide cognitive behavioral therapy (CBT), a counselling technique that helps patients identify, avoid, and cope with situations in which they are most likely to abuse drugs or alcohol (Butler, Chapman, Forman, and Beck, 2006). For some individuals (i.e. individuals addicted to opiates) addiction treatment may include short-term medical management of withdrawal symptoms by physicians and nurses prior to the treatment outlined above. Addiction treatment is provided to clients who voluntarily source treatment on the assumption that voluntary participation is essential to successful treatment because it reflects clients' willingness to acknowledge and take responsibility for alcohol and drug use.

Evidence of shortcomings of, and questions about, this traditional approach to addiction treatment started to emerge in the early 2000s in the national arena and in the province of Alberta. Even with substantial efforts to treat addiction using the traditional approach the incidence of addiction seemed only to be increasing (AADAC, 2005a; CECA, 2004). As well, the need to create connections between traditional addiction treatment and other services was becoming apparent. A

national conversation about individuals with addiction and mental health illness identified that this subpopulation was 'falling through the cracks' and bouncing between addiction services and mental health services (Canada Parliament Senate, 2006). This shaped a provincial conversation about the lack of, and need for, connections between addiction and mental health services (AADAC, 2005b; 2006b; Alberta Health, 2008). Addiction was also becoming a concern in other sectors, for example in the Human Services sector where the connection between addiction and homelessness was being discussed (Alberta Government, 2008), and in the Justice and Crime Prevention sector where the issue of addiction and crime was drawing attention (Alberta Government, 2007; Alberta Justice, 2007).

In 2007, in Alberta, the Alberta Family Wellness Initiative (AFWI), a 'pro-active private foundation' (AFWI, 2015a), started to host an annual symposium for key policy makers, organizational decision makers, and professionals. At these symposia, participants were introduced to 'the large and growing body of scientific knowledge around epigenetics and developmental and behavioral neuroscience' which AFWI positioned as a 'scientific platform for innovation' that would 'redirect resources toward broad health promotion and disease prevention strategies' and ultimately 'help break the inter-generational cycle of … addiction' (AFWI, 2015a). Hand selected actors from different sectors (e.g. Addiction, Health, Human Services, Community Development, and Justice) attended these symposia, listened to the science presented, and worked together in cohorts and on innovation teams to explore how this science might affect policy and practice in the province.

In 2008, AADAC released a *Review of Addiction Service in Alberta*, in which the organization described an 'opportunity to improve and redesign the system of addiction services in Alberta in a thoughtful, co-ordinated and congruent way' (2008: 8). In this document, AADAC

describe a 'tiered model' for Alberta in which 'strategic partnerships across government departments and community organizations, and within the health-care system and social service system' would be developed (AADAC, 2008: 9). Before AADAC could start working towards this intentional redesign of the system, the Alberta Government disbanded AADAC, the province's nine health regions, and the Alberta Mental Health Board, forming a province wide health authority – Alberta Health Services (AHS). Within this new health organization, AADAC and the Alberta Mental Health Board were combined into the *Addiction and Mental Health Department*. Within this department, actors started to work on connecting addiction treatment with other health services including mental health, public health, and physicians' general practice.

My examination of the field of addiction treatment started in 2011. I first engaged with a micro setting, examining two community clinics created by AHS that co-located professionals with addiction expertise and professionals with mental health expertise. The clinics presented an opportunity to examine managers' and professionals' actions aimed at disrupting traditional addictions treatment practice and developing integrated and collaborative addiction and mental health practice. (Refer to *The Addictions and Mental Health Clinics* for a detailed description of the clinic). During my research project, which was conducted over three years, I interviewed AHS senior managers who spoke not only about the clinics, but also about the actions being taken in AHS to connect addiction treatment to the broader health system (i.e. to general physician practice and to public health services). Through these interviews, I recognized that the clinic research was exploring disrupting work at only one level – a micro level – and I started to search for opportunities to explore disrupting work at the field level. In 2013, I connected with the AFWI organization and started to attend their annual symposia. Through these interactions with field level actors I was able to shape a field level study to explore the intentional and purposefully ways that

field actors were disrupting arrangements and practices in the addiction treatment field.

Field actors involved in disrupting work

After attending the AFWI symposia in 2013, hearing the research presentations, and listening and talking to symposium participants, I recognized that these actors were taking purposeful and intentional actions aimed at disrupting traditional arrangements and practices of addictions treatment. I classify the actions of these individuals as 'disrupting' rather than 'creating', as the intent was not to create a 'new' system but to interrupt and build upon what currently existed. Indeed, actors recognized value in traditional addiction treatment, but saw an opportunity to build on this, taking addiction treatment to new clients and new spaces and layering and mixing other practices into addiction treatment.

Through my research involvement with AFWI, (involvement that remains ongoing), I met policy makers and organizational representatives. These actors had been 'pre-screened' by the AFWI and invited to participate in the symposia either because they were already involved in 'disruptive' activities or because they were in positions that would allow them to actively move new ideas about addiction and addiction treatment through their organizations and professional networks. The macro part of my study explores the actions of these field level actors who, with intention and effort, were disrupting the Alberta addiction treatment field.

The addiction and mental health clinics

In this section, I describe the two Addictions and Mental Health Clinics in which I conducted the Part 2 study of disrupting professional practice. In this study, I examined professionals' work, the routines and activities they engage in on a day-to-day basis (e.g. Barley and Kunda, 2001; Nicolini, 2009). In order to avoid confusion when talking about actors day-to-day 'work' and the concept of 'institutional work' I adopt the convention of referring to day-to-day routines and

activities as 'practice'. As described previously, the practice of addiction treatment is behaviorally oriented. Through one-on-one and group treatment and counselling, led by either psychologists, social workers, or addiction counselors, professionals' goal is to change clients' behavior in relation to drug and alcohol use.

Addiction treatment in Alberta has never been well connected to other services. In particular, addiction treatment has not been connected to mental health services (provided by psychiatrists and nurses) even though many individuals with addiction also cope with mental health issues[1]. In 2008, after the formation of AHS, the Addiction and Mental Health department designed and implement co-located community clinics that brought together psychologists, social workers, addiction counsellors, psychiatrists, and nurses. Senior management expected the clinics to improve clients' access to services, but also to provide space where professionals could integrate addiction treatment and mental health treatment, developing through this integrated and collaborative practice. In my study, I examined the first and second clinics in which addiction services and mental health services were co-located. These clinics represent matched cases (Kellogg, 2012). Both were overseen by the same local zone of the province's health authority, both were located in community settings, both co-located professionals with mental health expertise and professionals with addiction expertise, and both located psychiatrists and clinic managers off site.

I started my research in Clinic A, the first co-located clinic, entering the clinic approximately 18 months after it opened. I later examined Clinic B, also approximately 18 months after it opened.

[1] Mental Health Services, provided by registered nurses and psychiatrists, include the pharmacological treatment of mental illness, understood to arise from chemical imbalances in the brain. Because use of substances (drugs and alcohol) can mimic and mask symptoms of mental illness, psychiatrists and nurses have required individuals to be 'clean' from drugs and alcohol prior to accessing treatment for mental health issues. Clients using drugs alcohol are referring to addiction services and are expected to follow through and complete the referral and traditional addictions treatment prior to contacting the mental health system. The experience for clients was to 'fall through the cracks' – bouncing between the mental health sector and addiction treatment sector (AADAC, 2006b; Kirby and Keon, 2006).

I immediately noticed that practice in Clinic A and Clinic B were different, and that Clinic B practice was really not very different from the traditional approach to addiction treatment. My interviews with Clinic B professionals and mangers and my observations of this clinic showed that professionals were practicing independently, had not integrated tools of practice, and were following the traditional mental health case conferencing activity. While actors in Clinic B supported integrated, collaborative practice, I did not get the sense that they were actively engaging in intentional action aimed at disrupting practice. Thus, as my interest was to explore purposeful, intentional disrupting action I ended my research involvement with Clinic B for the purpose of my dissertation research. In following, only data from Clinic A is included in my dissertation research.

Detailed description of Clinic A. Clinic A opened in 2008, occupying custom designed space on the second floor of a new inner city community public health center. AHS senior management described Clinic A as a 'center of excellence', a 'flagship center':

> [The clinic] has a mandate … it is guided by an intentional strategic plan … to develop and work towards concurrent capable staff and to be able to influence the strategic principle of any door is the right door ... it's their opportunity to work together to [change] practice and to be able to trial approaches … to demonstrate integration' (AHS, Senior Manager)

The multi-profession team was comprised of a registered nurse, a psychologist, a social worker, an addiction counsellor, and psychiatrists (physicians). The social worker, counsellor, nurse, and psychologist worked full time, Monday to Friday. The psychiatrists worked part time, providing consultations three half-days most weeks. Two managers were responsible for the clinic, one representing addiction and one representing mental health (reflecting the parallel management structure of the Addiction and Mental Health department). Clinic managers and professionals had substantial leeway to interrupt traditional practice, recognizing that the clinic was 'one of the first to ever [bring addiction and mental health together] … there is no precedence' (Manager, addiction services). They also recognized that no one in the broader organization really knew what they

wanted from the clinic and that although 'high up [management] had this plan … idea' it was 'clear pretty quickly … how to do it was being developed from the ground up' (Addiction Counsellor).

When Clinic A first opened, managers and professionals spent time discussing what it meant to bring addiction treatment and mental health treatment together, and what it meant to be 'concurrent capable' with respect to addiction and mental health. They created opportunities to work together, to consult with each other, and to learn from each other. Over time, a clinic practice evolved that brought together traditional addiction treatment practice and traditional mental health practice. Similar to the categorization of field level work as disrupting, I categorize actors' actions in the clinic as 'disrupting' because their intent was to interrupt traditional practice and to rebuild it into something different not replace it with new practice. Part 2 of my study explores the actions of these micro-actors who, through intentional and purposeful action, disrupted traditional addiction treatment practice.

A Qualitative Case Study, Data Sources, and Interpretive Data Analysis

My aim to examine institutional disrupting work supported qualitative research, an appropriate form of research when exploring phenomena that requires researchers to develop a 'complex, detailed understanding' of the phenomena and of the context within which the phenomena is situated (Creswell, 2013). In organizational research, qualitative approaches have long been adopted by scholars interested in developing process theories (e.g. Langley, 1999; Langley, Smallman, Tsoukas, and van de Ven, 2013; Van de Ven, 1992), and thus the qualitative approach also fits with the goal of developing process models of disrupting work. In this research, the ontological assumption is that the actions and interactions of actors underpin institutional life (e.g. Jepperson, 1991; Berger & Luckmann, 1967). In order to stay true to this philosophical assumption (Creswell, 2013), the research was designed to draw out as much as possible

'participants views' about 'the world in which they live' and work (Creswell, 2013: 24).

Following other institutional scholars I designed a case study (Currie et al., 2012; Lawrence et al., 2009; Micelotta and Washington, 2013; Reay and Hinings, 2005, 2009; Reay et al., 2006; Smets et al., 2012) and within the bounds of this case study explored disrupting work. The instrumental case study (Stake, 1995) allowed me to focus on 'a single issue or concern' (Creswell, 2013: 99), disrupting work. During, and after, data collection I used grounded theory techniques in data analysis to 'elicit fresh understandings about patterned relationships between social actors' (Glaser & Strauss, 1967) and to generate 'a general explanation … shaped by the views of a large number of participants' (Creswell, 2013: 83). My research design allowed me to investigate a complex social environment and provided a foundation from which I was able to develop an in-depth understanding of social action and processes.

Data Sources

In case studies researchers collect multiple forms of qualitative data (Stake, 1995; Creswell, 2013). While interviews form the bulk of the data collected, additional data collected in the form of observation data and documents can be helpful in developing a more robust understanding of complex social processes and action (Stake, 1995).

Interviews

I conducted in-depth interviews with research participants (Miller and Crabtree, 2004; Rapley, 2004). In the interviews my goal was to have participants describe their 'views of their worlds, their work, and the events they have experienced or observed' or participated in (Miller and Crabtree, 2004; Rubin and Rubin, 2005). I used a technique called 'depth interviewing' which conceptualizes the interview as a 'listening space where meaning is constructed through an interexchange / co-creation of verbal viewpoints' (Miller and Crabtree, 2004: 185; Rapley, 2004). This type of

interviewing is appropriate when 'the focus of inquiry is narrow, the respondents represent a clearly defined and homogenous bounded unit with an already known context' and when respondents are comfortable with interviews as a means of communication (Briggs, 2007; Miller and Crabtree, 2004: 186). The intent of the interviews was not to generate holistic ethnographic information, but rather to focus on a 'fairly specific research question' (Miller and Crabtree, 2004: 186-188).

For Part 1 of the study, I wanted field level actors to describe how they were disrupting arrangements and practices of addiction treatment in their organizations or in the field. I asked them questions such as, 'How is addiction treatment provided in your organization?' and, 'Have treatment programs or services changed, and how?' I asked them to speak to new inter- or intra-organizational connections made through their AFWI involvement and to the actions being undertaken in relation to these new connections. I also specifically asked, 'How are you moving AFWI information into your organization?' These interviews were conducted with individuals who were theoretically sampled (Glaser and Strauss, 1967). I reviewed the AFWI attendee list and contacted individuals whose organizational and professional roles were in some way connected to addiction (e.g. representatives of not-for-profit organizations, mental health and addiction service providers, residential treatment facilities, AHS) and representatives from government departments (e.g. health, human services, justice). I also completed an independent environmental scan to identify other organizations that might be usefully included in the theoretical sample. This search identified one organization that was not an AFWI attendee. I contacted all participants via email, describing my research and indicating that I was interested in changes in addiction and addiction treatment in Alberta. Interviews took place between 2013 and 2014. A list of interviewees is provided in *Table 2: Field actor interviews*.

Sector and Organizations	**Interviews**
Government	Human Services
	Education

Sector and Organizations	Interviews
	Justice
	Alberta Health x2
	Alberta Health / Human Services
Drug Courts	Provincial Courts
AHS	Manager – Urban Clinic
	Director – Forensics, Addictions
	Manager – Community Clinic
	Director – previously AADAC
	Director – previously AMHB
	Senior Manager – previously AADAC
	Senior Manager – previously AMHB
	Director - Strategic Care Networks
Professional Association	Psychology Association
Not-for-Profit	Street Works
	CASA X2
	Safe Harbor
	MCMAN X2
	United Way
	Simon House
	Treatment Center - Physiologist
	Kerby Center
	Servants Anonymous
	Calgary Women's Emergency Centre
Community Services	FCSS
Public	Provincial Council Addiction and Mental Health - member

Table 2: Field actor interviews.

In Part 2 of my study, I interviewed managers and professionals from Clinic A, and AHS senior manager and directors in the Addiction and Mental Health Department. In these interviews, I asked participants to describe the rationale for the clinics. I also asked participants to speak to the clinic and its purpose, and to speak to practice in the clinic focusing on how practice was developed and how it differed from practice in traditional settings. Participants talked about the context of their work, the problem(s) they were working on, the tools and activities they had developed, and how they interacted with each other. In Clinic A, I interviewed each member of the professional staff two times. Clinic managers were interviewed three times each, once in a joint interview. I conducted approximately 25 hours of observation in Clinic A. AHS senior managers were interviewed twice, and Directors once. A summary of data collection in Clinic A is presented in *Table 3*, below.

Clinic opens	Yr 2	Yr 2.5	Yr 3	Yr 3.5
Interview #1	AS Manager MH Manager Social Worker Addiction Counsellor Psychologist Director AS Director MH Senior Manger AS Senior Manager MH	Psychiatrist	Social Worker Addiction Counsellor	Psychiatrist Psychiatrist
Interview #2			Addiction Counsellor Psychologist Social Worker Registered Nurse	Social Worker Addiction Counsellor Registered Nurse AS Manager MH Manager Senior Manger AS Senior Manager MH
Interview #3			AS & MH Manager	
Observation		Observations 1 4 conferences, 2-4 hrs		Observations 2 4 conferences, 2-4 hrs

Table 3: Clinic A interviews and observations by year of Clinic operation.

During the interviews, professionals had trouble describing the work they did in the clinics, often talking about work through client stories. To encourage them to talk about their actual day-to-day activities and routines, I asked them to describe activities they did as solo-practitioners and activities they did together. I also asked them to talk about collaborative interactions. For example, I asked them to describe how they presented cases in case-conferences, what kinds of questions they were asked, and how they responded to these questions.

All participants agreed to have their interviews digitally recorded and audio files were stored on a secure server. I transcribed twelve of the interviews to electronic documents (.doc files) listening to audio and typing text. I also used Dragon voice transcription software as a tool for transcription. Due to time constraints, interviews were also transcribed through a transcription service. Interview data also included the notes I made immediately following each interview, which I compiled in a field journal. In these notes, I recorded my own thoughts about interviews and what was discussed in the interviews.

Documents

Documents collected in the Part 1 Field study included government documents, organizational evaluations, and research reports. I located relevant government documents by systematically searching Government of Alberta department websites for policy documents, and within these searching for any reference to addiction. Government documents provided contextual understanding and as well provided some insight into particular disrupting actions. I also collected non-government documents, specifically *research reports* and *evaluations* of projects undertaken in relation to addiction treatment. Participants directed me to organizational research reports and to resources on the AFWI website. The AFWI documents helped me understand how addiction was understood in Alberta, and where disrupting actions were being aimed. The evaluation reports provided insight into the actions of actors in the field. For Part 2 of my study, documents provided both contextual information and insight into practice disrupting. In the clinic study, I collected documents that described the intent of the clinic and I collected documents used in professionals' day-to-day work. *Table 4: Summary of documents* provides an overview of the documents.

Document Source	Document Type	Number of Documents	Years Covered
Government	Health, Justice, Human Service, Education Strategic documents, business plans, evaluations, media releases	38	2007-2014
AADAC	Historical Document, research, evaluations, position papers, environmental scans, service summaries, service reviews	53	2001-2009
Not-For-Profit	Strategic plans, operational plans, webpage data, evaluations	25 + webpage data	2007-2014
Other Organizations	Provincial associations, strategic plans, information for members	8	2009-2014
Alberta Family Wellness Initiative	Presentation power-points and videos; symposia summary documents, resource material + field notes developed while attending the symposia	112	2010-2014
Clinic Documents	Addiction Services and Mental Health Services traditional assessment tools. Combined and integrated assessment tools and client file (blank). Integration assessment documents. Strength Based Presentation Forms.	18	2010-2013

Table 4: Summary of documents.

Observations

I also conducted observations for both Part 1 and Part 2 of the case study. Observation data was collected to bring a different perspective to the research (Atkinson and Coffey, 2002). The Part 1 study observations were completed during the annual AFWI symposia. During the symposia, I made notes during all of the expert presentations, during the question and answer periods that followed presentations, during cohort sessions, and innovation team sessions. At the end of each day, I recorded the nature of interactions and discussions, the overall organization of the symposia, and general impressions about the symposia. When I was observing at the AFWI, I attempted to remain in the background. However, attendees knew I was conducting dissertation research and they openly included me in their discussions, allowed me to gain a nuanced understanding of their involvement and interactions in the symposia. AFWI observation data presented in this research is necessarily general to protect the confidentially and anonymity of AFWI attendees.

The observations for Part 2 of my study were extensive and provided analytical and contextual data. I recorded physical descriptions and general impressions of clinic space and of the interactions of professionals and managers. I also observed eight case conferences. Each case conference consisted of client presentation and discussions and administrative discussions. Each case conference lasted between 2-4 hours and at each between 8 and 15 clients were presented. When observing I focused on 'what … social actors actually did' (Atkinson and Coffey, 2002: 806). The observations helped me understand how professionals were presenting clients and discussing clients, and how they were acting towards one another within the clinic space. I took notes throughout the case conferences, and at the end of each session debriefed with managers and professionals. I transcribed my hand written notes later in the day so that the observations were still fresh in my mind. I recorded observation notes in my field journal.

Data Analysis

I analyzed Part 1 and Part 2 data separately, and in the following pages describe the approach used to analyze data.

Data analysis: Part 1

In the first stage of data analysis, I developed *sketches*. A sketch is a 'brief written … account [and] description, giving only basic details' but 'created to assist in making a more finished picture' (Oxford Dictionary, 2015). Each of the sketches developed was written from a particular perspective – government, health care, and not-for-profit service provider. I developed the sketches by drawing out sections of data from relevant interviews and collecting these in NVivo nodes (i.e. codes). In this activity, I systematically searched the interviews for segments of text that spoke to a) new ideas about addiction and the implications of these ideas; b) making connections between sectors and organizations; c) serving clients previously not served; d) changing organizations, policies, programs, and services. The sketches helped me become familiar with the data and helped draw out central concepts (Creswell, 2013: 183), which later I used to develop 'work' categories.

As an example, the sketch for Alberta Health Services drew together data from six AHS interview. Multiple interviews were used to develop the AHS sketch, as this is a large organization that provides extensive addiction and mental health services in Alberta (Wild, Wolfe, Wang, and Ohinmaa, 2014). Multiple data segments spoke to a 'new' understanding of addiction, connecting it to mental health and to early brain development. Other segments spoke to actors making connections between sectors (e.g. health and human services). Some data described the formal organizing actions being undertaken in AHS to integrate addiction and mental health. Another group included descriptions of specific projects being undertaken by AHS managers. After grouping segments of data, I created a few paragraphs of text around each group in which I

explored the following questions – *what are the actions depicted in the group of data* and *why are actors engaging in these actions*? Together these paragraphs created a sketch. I undertook a similar process for the remaining perspectives.

As I was creating the sketches I developed some insight into disrupting actions. I realized that although actors represented different field members, occupying different field positions and with different interests, a common vision of an alternate future was present. Actors were seeing the complexity – wickedness – of addiction and were recognizing that while the traditional approach to addiction treatment was helpful to some, in an alternate future the field would look different, for example integrated and collaborative treatment models would be available to a broader group of clients. All actors recognized that moving to this alternate future would be a slow process, but were committed to achieving small disruptions in the present time intending to aggregate these to shape broader disruptions over time.

The sketches provided the foundation for the next stage of data analysis, a 'data reduction' exercise (Glaser and Strauss, 1967). In this stage, I re-engaged with the first level concepts that represented specific action. I started this process with the data contained within the sketches (the initial 12 interviews), and then systematically searched the remaining interviews for supporting data until first level action categories were saturated. In this exercise, I also turned to the documents included in the data set (e.g. evaluation reports, AFWI summary reports, service provider plans) as these provided detail about particular actions. After saturating the first-order concepts, I aggregate these and connected them to the abstract categories of disrupting work developed from the sketches. In this last stage, I also connected to the extant literature on institutional work.

Data Analysis: Part 2

In analyzing the Part 2 data, I moved from data in field notes, observations, and interviews to

analytical and theoretical concepts, using NVivo software to help organize and aggregate data. Like in Part 1, I created sketches of professionals and managers' activities in the clinic. I collected segments of text in nodes, where each node represented an activity of professional practice. I reviewed these sketches with the managers and professionals to see whether they also felt that these accurately depicted work in the clinic (June 2014, presentation to Clinic A). I also verified Clinic A activities were different from traditional practice by comparing them to the activities of professional practice described in Clinic B. In Round 2 coding, I went back to the data compiled in Round 1, and started to explore the emergent properties of the data (Langley, 1999: 700), inferring how day-to-day activities were disrupting of professional practice from the data itself. Finally, I attempted to depict the codes and themes in a diagram to illustrate how the day-to-day activity of professionals and mangers were disrupting traditional professional practice.

Ethics

Because my dissertation research included human participants, I obtained ethics approval from the Research Ethics Board at the University of Alberta. I informed all participants that I was a PhD student, conducting research for my dissertation and that the data they provided would be used to develop peer review and practitioner articles. I received written consent from each participant (see *Appendix A: Recruitment and consent forms*). Participants who participated in telephone interviews were emailed consent forms, which they returned by mail. Participation in the study was voluntary and all participants were informed of their right to withdraw from the study at any time. To help with confidentiality, research participants are identified by professional designation, organizational role, or organization affiliation. Provincial departments are identified by service.

CHAPTER 4: FINDINGS (PART 1): DISRUPTING A MATURE FIELD WITH INCUMBENT PROFESSIONS

> It is clear … that we are moving towards understand an evidence science perspective [of addiction]. Understanding addiction as a type of mental health concern. … [Moving toward] tiered levels of service … [and looking at] promotion and prevention … [to] approach [addiction] from different ways. (Interview, Alberta Health)

In this Chapter, I present findings from my case study that explored actors' disrupting actions in the Alberta field of addiction treatment. The quote above shows that the field was moving towards something different, but hidden in this quote is the action The findings chapter is divided into two parts, aligning with the two parts of my case study. Findings (Part 1) describes the findings for the field part of the study showing how *actors disrupt a mature field with incumbent professions.* Findings (Part 2) describes the findings for the practice part of the study showing *how actors disrupt professional practice*.

How Do Actors Disrupt a Mature Field with Incumbent Professions?

Increasingly, actors in and around the Alberta addiction treatment field are becoming aware of the wickedness of addiction - that addiction it is not only problem of individual behavior but that it is connected to other many other issues. Actors are engaging in disrupting actions in order to interrupt traditional arrangements and practices of addictions treatment and in order to move the field towards an alternate future. In the next pages, I describe these disrupting actions.

Complexifying Work

Complexifying work is the first category of disrupting work engaged in by actors in the addiction treatment field. Complexifying work includes *bundling* addiction with social issues and developing and using metaphors to *disrupt simple framing* of addiction. Complexifying work disrupts disrupt traditional (simple) understandings of field issues and builds on these a more complicated and connected narrative.

Bundling problems

In Alberta, addiction was bundled with other problems in two ways. First, in government policy documents that bundled addiction with other social problems and second, within Alberta Health Services (AHS) where addiction was bundled with mental health.

Linking addiction to other social policy problems

In 2007 and 2008, Alberta government departments released policy documents that bundled addiction with other social policy issues. These documents clearly point to the connections between addiction and other social policy problems. While implicating addiction as a causal factor in social problems such as crime, homelessness, and poor health, addiction itself was not demonized. Instead, policy actors pointed to addiction as a 'disorder', a 'serious challenge', and one of a number of 'particularly challenging issues'. Absent in all policy documents, except one, is reference to the need to provide treatment that helps individuals change behavior. Instead, policy documents direct attention to the need to help 'specialized groups' by building encompassing supports around them. In these documents, policy actors clearly send a message that, going forward, the government will support 'action' in Alberta that is 'targeted', that is not 'band-aid', and that 'integrates' and addresses 'root causes'. In these documents government departments did not prescribe any particular courses of action, instead they only pointed to the connections between problems, letting other actors develop models to address the bundled problems.

> People are charged and convicted of crimes while their underlying problems of drug and alcohol addictions and mental illness – problems that fuel their criminal activities – are given "band-aid" treatment at best. (Alberta Justice, 2007)

> Addictions and mental illness frequently are co-occurring disorders. Alberta has recently taken steps to integrate these two previously separate areas of care. This will result in improved services … particularly for those with concurrent disorders. (Alberta Health, 2008)

> Many Albertans facing homelessness are facing other serious challenges … specialized groups – such as those with mental illness, those with addictions … are dealing with particularly challenging issues, and require special support to help address their unique

> situations. Targeted responses are required to effectively re-house homeless people from these specialized groups. (Alberta Government, 2008)
>
> One thing to keep in mind [as you are exploring addiction treatment in Alberta] is government generally follows the front line. Government is rarely ahead of the crowd. Because that would be risky. We don't do that. (Director, Alberta Health)

The writing and releasing of policy documents is action because these documents do not simply appear, they are intentionally crafted and released by (anonymous) policy actors. Bundling disrupts the traditional environment, drawing attention to what has been missed – connections and complexity - in prior arrangements created to resolve addiction. Bundling addiction with other social problems creates, overall, a more complex problem environment for actors involved in resolving addiction and problems connected to it. By bundling addiction with other social problems, the policy documents avoid an outright critique of traditional addiction treatment and arrangements, instead pointing to what has been missed – that traditional arrangements and practices have not addressed connections and complexity. The documents point to a future where integrated, targeted solutions are in place to resolve addiction and other social problems. In the face of bundling, incumbent field actors are put in a position where they can no longer claim that a particular expertise and treatment approach will suffice, on its own, to resolve a problem that is part of the bundle. They can, however, take the opportunity bundling presents to explore how particular expertise and treatment approaches can contribute to the envisioned alternate future.

Organizational bundling - linking addiction to mental health and chronic disease

In 2008, in a sudden restructuring exercise, the Alberta government disbanded AADAC, the Alberta Mental Health Board, the Alberta Cancer Board, and the province's nine health regions, and formed Alberta Health Services (AHS). In AHS, an Addiction and Mental Health department was formed and addiction services were bundled with mental health services. Bundling addiction and mental health in one department was justified on the premise that addiction and mental health were

concurrent disorders (i.e. disorders that occurred in individuals at the same time). While explicit data in support of concurrent disorders was still emerging (CCSA, 2009), the idea of concurrent disorders was generally supported by national organizations involved in the conversation about mental health and addiction. In 2006, for example, Canada's Standing Senate Committee on Social Affairs, Science and Technology had concluded that there was 'substantial overlap between mental health and addiction issues' and that many individuals were living with both problems (Canada Parliament, Senate, 2006). Other national organizations, expert in addiction and mental health, also supported the idea of concurrent disorders (CCSA, 2009, CAMH, 2015).

Bundling went beyond the organizational chart. In AHS, the terms addiction and mental health were consistently bundled in organizational documents (Alberta Health, 2008; Alberta Health and Alberta Health Services, 2011a, 2011b), intra-organizational communications, and in actors' conversations about addiction and mental health services. The issues were also bundled in a new role created within AHS, Addiction and Mental Health Therapists. In addition to the specific bundling of addiction with mental health, within AHS addiction was also bundled with other chronic diseases. Bundling addiction with other chronic diseases was a purposeful attempt by AHS actors to position addiction as 'another chronic disease' and through this reduce the stigma associated with addiction.

> [AHS will] increase public awareness and understanding of addiction, mental health problems and mental illness, thereby reducing stigmatization and barriers to access. Albertans will increasingly understand that addiction, mental health problems, and mental illness should be considered no differently than other illnesses and disorders. Over time, the stigma associated with addiction, mental health problems and mental illness will decrease, and barriers to accessing services will be significantly reduced … Language describing addiction, mental health problems, and mental illness will become more positive, accepting, and respectful. (Alberta Health and Alberta Health Services, 2011a)

> The research and evidence clearly indicates that there is actually not a lot of people who are just impacted by addiction - they have both addiction and mental health. (AHS Director)

> We recognize the importance and the contribution that alcohol plays in chronic disease

> management. Whether that's mental illness or any other kind of chronic condition … diabetes or cancer … (AHS, Addiction and Mental Health Strategic Clinical Network).

AHS' bundling of addiction with other health problems was disrupting to incumbent professions. Managements' bundling of addiction with other health issues was very difficult for professions to criticize, especially in a system that emphasizes chronic disease management models (AHS, 2015). Bundling addiction with mental health allowed managers to connect the two problems, drawing professionals' attention to the problem's cross-jurisdictional orientation and to already legitimized models of disease management, encouraging them to consider how principles of chronic disease management might be applied in the context of addiction (e.g. multi-profession collaborations). It also granted managers organizational authority to explore different service delivery arrangements, even in the absence of explicit support from incumbent professions. Like with policy bundling, bundling problems in a high profile organization is disrupting to incumbent professions because incumbents must respond to organizational directives in a positive way. Outright resistance towards organizational bundling, and initiatives that support this, appears self-serving and interest-driven, making organizational bundling a difficult disrupting action for incumbent professions to neutralize.

Disrupting simple framing

In Alberta, field actors worked to disrupt the simple framing of addiction as an individual-behavioral issue by *developing and circulating metaphors,* and *circulating and using metaphors* that supported a more complex picture of addiction, one that did not fit within the traditional frame.

Developing and circulating metaphor

The Alberta Family Wellness Initiative (AFWI) is an action oriented foundation with a mandate to connect 'early brain and biological development and children's mental health with addiction research, prevention, and treatment … [and] to translate current research into sound

policy and practice on behalf of Alberta' (AFWI, 2015a, 2015b). AFWI, with input from the Harvard Center on the Developing Child and the FrameWorks Institute, developed a video entitled *How Brains are Built: The core story of brain development* (http://www.albertafamilywellness.org/resources/video/how-brains-are-built-core-story-brain-development). The message provided by this video had 'high fidelity to the science' of early childhood development and the science of addiction and drew upon 'metaphors developed by FrameWorks and [empirically] tested with audiences both in the U.S. and in Alberta' (AFWI, 2013). In the video metaphors such as *'brain architecture', 'toxic stress', serve and return',* and *'executive function'* were used to connect early brain development with addiction. Through metaphors, AFWI drew a picture of addiction as a 'chronic disease of brain reward and motivation systems, with its roots in toxic stressful experiences' of early childhood (AFWI, 2010), a picture that did not fit the traditional understanding of addiction.

AFWI presented the *How Brains are Built* video and metaphors to symposia participants (policy makers, organizational decision makers, and professionals) starting in 2010, and made resource available through their website (AFWI, 2013). Symposia presenters employed the metaphors in their presentations in the 2011 through 2014 symposia, linking them to specific research interests such as adverse childhood events and the neurobiology of addiction (AFWI online resources; Observation field notes). AFWI organizers were relentless in their use of the metaphors, drawing them into opening remarks, into closing remarks, and into work session and discussions throughout the symposia (Observation field notes). They were also relentless in encouraging participants to distribute the video and metaphors in their professional and organizational networks, holding participants accountable for this in semi-annual report-back calls during which senior AFWI representatives asked each participant to describe how he or she had distributed the video (Observation field notes). AFWI's 2012 summary report described how provincial actors were

integrating 'symposia knowledge into committee work, strategic plans, policy briefs, and external communications' (AFWI, 2012: 9). Organizational documents also showed that AFWI metaphors were being used to shape organizational policy:

> Our current understanding [is] that addiction, mental health problems and mental illness are caused by a complex interplay of genetic, biological, personality and environmental factors … the basic architecture of the human brain is constructed … exposure to chronic and serious early stressors… may erode the solid foundation on which mental health develops. This leaves affected people without the stability they need to be able to adjust to situations and function effectively. (Alberta Health and Alberta Health Services, 2011a)

AFWI was purposeful and intentional in developing and actively circulating new metaphors. They engaged the services of highly regarded organizations (FrameWorks and Harvard University) to develop empirically tested metaphors that would have strong resonance with audience members whether these were professionals, organizational decision makers, or policy makers. Because all participants were exposed to the metaphors at the same time, AFWI created an opportunity for participants together to explore how the metaphors could be spread through organizations and professional networks. AFWI's actions aimed at developing and circulating new metaphors and imagery about addiction were interpreted positively by field actors including incumbent professions, who enthusiastically circulated the metaphors in their networks.

Circulating and using new metaphors in organizations and professional networks

The metaphors created by AFWI were actively circulated through organizational and professional networks. Professionals incorporated the metaphors into their every-day activity and talk and were making attempts to spread the metaphors through their organizational and professional networks (Observation field notes). Professional association representatives said that their members found the metaphors helpful in articulating how their practices – treatments and models – were useful in treating addiction. At a policy level, actors used metaphors to engage with sectors (and professionals) that previously had not considered addiction as concern. Actors also

used the metaphors to help explain the rationale behind programs that were purposefully drawing addiction treatment into new sectors. In organizations, the videos were included in training and education sessions, introducing the metaphors to a broad range of professionals and occupational experts. In some organizations, managers suggested that the metaphors had helped change staffs' language and focus away from specifics of substance use and towards individuals' reactions to stress.

> I have sent the [AFWI] videos out to front line staff … from a secretary … all the way through to psychology, it is one of those tools that is valuable. (Manager, Alberta Health Services)
>
> [The Brain Story] … provides some language for psychologists to use … they normally [get] lots of pieces of information … groups like [AFWI are] … pulling together the pieces and saying … here's some ways to articulate that story in a way that's more clear. (Psychology Association)
>
> [AFWI has] been able to break [science about addiction] down in a way that it is easier for us to explain … why we do what we do. Our own staff [included]. … don't always understand why we do [particular programs around addiction] … What comes out of the [AFWI] conferences … is a way of saying to our staff, 'This is the why' … we can get the message across very succinctly. I incorporate … videos on the brain architecture … into our induction training. All new staff receive that video and it's a way of saying … we still have a chance to have some positive change. (Manager, Justice)

The development, circulation and use of new metaphors in mature fields with incumbent professions is action that is disrupting because it interrupts language and imagery of the field's issue. The metaphors, however, do not devalue incumbent professions' traditional practices, instead they provide a means to investigate and talk about how traditional practice fits within new imagery. New metaphors have to be of a certain type to have a disrupting effect. The AFWI metaphors were built from science and were empirically developed and tested for resonance and for their ability to 'shift frames'. Professionals and organizational actors liked that the metaphors were developed scientifically and had no qualms using and spreading the metaphors through their networks. Ultimately, the metaphors, while simplifying science, were used by actors to show how existing

arrangements and practices could fit within more complex solutions.

Boundary Work

In and around the field of addiction treatment, actors have been increasing interactions between previously unconnected actors by *creating neutral ground to explore connecting opportunities* and *working collaboratively and in partnerships to design programs and services*, thereby *disrupting organizational and sectoral boundaries*. They have also been *encouraging professional to be more inclusive in their practice* and *pulling addiction treatment into other sectors*, thereby *shaping an inclusionary boundary* around addiction.

Disrupting organizational and sectoral boundaries

Creating neutral ground to explore connecting opportunities

Starting in 2008, AFWI brought together, annually, a diverse group of actors to learn about the science of early brain development and its connection with addiction. The first symposia, *Recovery from Addiction* (2008-2009), focused on disseminating research on addiction to key decision makers. The second symposia, also called from *Recovery from Addiction* (2011-2012), continued to bring scientific research forward but this time included researchers, policy makers, and professionals. The third symposia, *Accelerating Innovation* (2013-2014), brought together the researchers, policy makers, and professionals who attended the *Recovery from Addiction* symposia with participants who had attended the AFWI's *Early Brain and Biological Development* symposia.

> The Symposium series involves roughly 100 participants, who are invited back each year to build upon their experience and knowledge. Participants are change leaders selected for their unique capacity to influence research agendas, cross-ministerial collaboration, policy development, decision-making, professional development, training, program design, and practice. They also represent the broad impact of early childhood development, mental health, and addiction across society, from academics, health, and education to justice and human services. (AFWI, 2012).
>
> Prior to their participation in AFWI activities, some participants were unaware of the vast ecosystems of organizations working on [the areas of addiction and early childhood

> development], and how their work fit into improving the outcomes of individuals and their families more broadly. (AFWI Evaluation, 2014)

AFWI organizers did not leave the opportunity to explore connections to chance. They assigned all symposia participants to Cohorts, groups of approximately 40 individuals that met every afternoon to discuss each mornings' expert panel presentations. AFWI organizers facilitated Cohort discussions, eliciting comments from different participants. I observed, in these discussions, participation from actors representing sectoral, organizational, and professional interests (Observation field notes). In the discussions, participants were complimentary of how addiction treatment services had been provided, even as they stated that going forward new models needed to be developed from these. AWFI organizers also formed Innovation Teams and assigned symposia participants to these teams. Innovation Teams were small group of 8-10 individuals, representing different interests (e.g. government, health, social services, and professions), different sectors (e.g. education and addiction treatment), and different time-periods (e.g. early childhood development and adult addiction treatment). Innovation Teams met daily during the symposia, remained in contact throughout the year, and then re-connected at the next year's symposia (Observation field notes). The Innovation Teams were another carefully crafted opportunity to explore connections between actors, who in their regular day-to-day lives would have no reason to connect. Finally, AFWI symposia organizers encouraged participants to intermingle and learn about each other's work, facilitating this by providing comfortable spaces in which to mingle (Observation field notes).

In a mature field, incumbent professions and organizational actors will tend to connect with other actors in the field more so than with actors outside of the field. These inward facing interactions reify field boundaries, and specific actions are necessary to disrupt the boundary so that actors can explore different connections. However, the actions by which boundaries are disrupted

are important. The opportunities to explore connections during the AFWI symposia arose because AFWI organizers carefully orchestrated opportunities. The AFWI created, and maintained over time, neutral spaces where actors with different interests could interact and explore connections in support of AFWI's mandate, not their own interests. Even though these opportunities to explore connections were in a way imposed on participants, from the participants' experience exploring connections was rather organic, simply happening as they participated in the symposia, the Cohorts, and the Innovation Teams. On the surface, the AFWI Symposia brought together a heterogeneous group of actors to learn about neuro-scientific and epigenetic research relevant to addiction. Under the surface, the AFWI symposia provided an opportunity for actors with different interests, including incumbent professions from the Alberta addiction treatment field, to explore how their work could be connected in a way that was non-confrontational, engaging, and supportive.

Working collaboratively and in partnerships to design programs and services

Since 2008, new connections have been developed between government sectors and between organizations. Actors have created inter-sectoral government collaborations and inter-organizational collaborations in order to design actionable policy and programs for target groups. These collaborations are an intentional attempt to redesign programs and services to create collective impact at the client level, placing the client centrally, and then drawing a variety of services together around client needs. These inter-sectoral and inter-organizational collaborations and partnerships included, as part of their membership, representation from the field of addiction treatment –professionals and organizational representatives – ensuring that the experiences and interests of field incumbents were included in the plans and projects developed.

> In terms of … drugs and alcohol, which is a part of the addiction mental health world, we have the Alcohol Strategy … there's a steering committee and an advisory committee …. That's a partnership between Alberta Health, Alberta Health Services and Alberta Gaming and Liquor Commission … There's currently a media campaign promoting responsible

> drinking. … There's also the dissemination of low risk drinking guidelines which is occurring through Alberta Health Services (Alberta Health)
>
> We're the voice of psychology in the province we have many ministries invite us to their meetings, planning meetings … children's services, addiction, mental health … Our job is to represent professional psychologists and consumers (Alberta Psychology Association).
>
> We are part of the Red Deer Housing team … [we link with] staff at Canadian Mental Health … Women's' Outreach and Domestic Violence. (Safe Harbour)

Working in collaborations and partnerships is boundary disrupting to a mature field with incumbent professions. The boundary around the field of addiction treatment was a *problem boundary* – it separated the problem of addiction from other problems and ensured that addiction treatment was accessible only to clients afflicted with the problem of addiction. (Similar problem boundaries existed for other social concerns (e.g. education, homelessness)). Prior to the collaborations and partnerships, each problem boundary existed in its own space. Working in collaborations and partnerships was an intentional effort to redraw boundaries around clients, disrupting traditional problem boundaries where this made sense. In sections of overlap, disrupting would be very evident, but the boundary as a whole would remain in place. The inclusion of incumbents in these partnerships and collaborations ensured that incumbents understood how and why boundaries were being disrupted, and allowed them an equal voice at the table. Importantly, while professions' voices were present they did not dominate in these collaborations and partnership as traditional addiction treatment was incorporated, but did not dominate, the projects and services designed.

Bringing addiction and mental health together in AHS

As described earlier, actors had formed a department of Addiction and Mental Health within AHS. After the department was formed, directors and managers worked to bring addiction services and mental health services together. In the department, directors first set up a dual management structure, reflecting the previously separate management of addiction services and mental health

services. Directors and managers recognized that dual management was particularly beneficial for professional staff, allowing them time to acclimatize to shared incumbency in the new organization. Over time, the management structure in AHS evolved incrementally, starting with front line services where addiction and mental health programs were transitioned to single management. AHS managers implemented other initiatives that disrupted intra-organizational boundaries between addiction and mental health services. A quality service-planning umbrella was created, and under this umbrella professionals with expertise in addiction and in mental health were asked to consider how integrated services might affect existing practice. The intent of quality service-planning was to create space within which new ideas could germinate and subsequently influence AHS operations, and over time professional associations' terms of reference. Another example is the Addiction and Mental Health Strategic Clinical Network (SCN), which brought together managers and professionals to improve the uptake of evidence into addiction and mental health treatment.

> [AMH] used to have [a] dotted line reporting [but] ... you get to a point where that dyad becomes counter-productive … [an you realize] we just need to be supervised as an integrated service. … However, at the beginning if you don't start off that way then you end up one group sort of losing their identity. … You have to start off very cognizant that you have an number of different skilled providers who are doing something a little bit different … as they mature they can go into an integrated service delivery model of management. (Director, Alberta Health Services)

> The [strategic clinical] networks were instituted within Alberta Health Services roughly two and a half years ago … Addictions and Mental Health was one of those first networks … designed to bring good clinical evidence into everyday practice in a quicker and more efficient manner. … [At the core is] a very small leadership team comprised of a senior provincial director, a scientific director, a senior medical director, an executive director and a manager. … [Plus] larger networks of people that represent a whole host of areas including all of our operational zone leads, Alberta Health, the non-profit world … professional practice leads from social work … psychology … front line staff … physicians, psychiatrists as well as family GPs … about half the larger broader group is physician based. (AHS, SCN)

Within AHS, directors' and managers' actions were all aimed at incrementally disrupting boundaries that traditionally had separated professionals with expertise in addiction from professionals with expertise in mental health. Some actions were aimed at disrupting formal

organizational boundaries, for example, shifting toward a management model in which a single manager would be responsible for a mixed professional staff. Other actions were aimed at disrupting boundaries of practice. The quality service planning project, for example, was an intentional effort to encourage professionals themselves to explore how their practice might extend past the rather bounded provision of addiction treatments to addiction clients. While intentional, these boundary disrupting actions were respectful of professionals' expertise and experience, and were incremental in scope. Rather than, for example, imposing new integrated practice expectations on professionals, managers provided space for professionals themselves to consider what boundaryless practice might look like.

Shaping an inclusionary boundary

In the field of addiction treatment, field members provided addiction treatment services to individuals with addiction problems. The boundary that enclosed field members and clients with addiction was an *exclusionary boundary*. Actors within the boundary were excluded from receiving care from outside of the field, for example care for health issues such as mental health.

> If [professionals] find somebody whose needs expand beyond [their] domain then that becomes a criteria for exclusion … in addiction service … [and] mental health services this issue has been going on forever. As soon as you indicate that you have concerns regarding substance use and I'm a mental health service provider I say, 'There is a group that is better suited to help you' … [and] send you [to addiction services] (Director, Healthcare)

> There [is] stigma [with addiction] … many, many service providers within health care don't want to deal with people with [addiction] … within our addiction group about 2/3 of them are not actively involved in a primary care relationship with a family physician and largely that is because they aren't welcomed into family practices or into relationships with physicians … if somebody has an addiction and they are really complex and really demanding there's the stigma. (Director, Healthcare)

> [We are] working on a project right now [with and inner city emergency department] to help the inner city people [with addiction] work better with medical professionals, who have in the past tended to judge and stigmatize our community. (Not-for-Profit)

Encouraging professionals to be more inclusive

In AHS, managers encouraged professionals to be more inclusive in their practice. Managers pushed professionals to draw connections between mental health and addiction and between other health concerns and addiction. They, for example, co-located professionals with expertise in addiction and with expertise in mental health in the same clinical settings, encouraging professionals to learn more about, and find connections between, each other's practice. In some hospitals, nurses with expertise in addiction were located on inpatient units to consult with clients whose medical history suggested addiction problems. The work of these nurses was to draw attention to clients' addiction problems so that treatments could be more inclusive – addressing both physical health and addiction. Senior management also developed a mental health therapist role (MHT) for regulated social workers, psychologists, nurses, psychiatrist nurses, and occupational therapists regardless of previous affiliation (i.e. with addiction service or mental health services). The idea underpinning the MHT role was that actors in the role would have difficulty excluding addiction clients from their practice. Throughout AHS, management communicated a new expectation for professional staff – that professionals would increasingly broaden the scope of their practice to become inclusionary. Reinforcing this expectation was education efforts that positioned addiction and mental health as concurrent disorders, and which focused on connections in the process drawing attention to the complementary work of addiction and mental health experts.

> Since the formation of AHS … we've taken that collaborative care concept and said we have a standard and an expectation that we want all addictions staff and all mental health staff to be concurrent disorder capable so that we are not duplicating care except in those situations when we truly need to have both specialists involved … our expectations of professional staff is that you build on your foundational skills and abilities and knowledge … to be able to effectively engage, screen/assess, and either treat or make appropriate referral if it is outside of your abilities and outside of your scope, but think more broadly about what your scope is (AHS, Director)

> The [emergency department mental health] team … they are all mental health staff. We [now] have one addictions counselor at [the hospital] who consults to and works with all of the mental health programs at that site. (AHS, Senior Manager)

Outside of AHS, actors also worked to encourage professionals to be more inclusive around addiction. In some AHS zones, representatives worked with Primary Care Networks (separate organizations to AHS) to encourage general practice physicians to bring clients with addiction into their practices. Managers in not-for-profit organizations, in a similar manner, encouraged local physicians to provide services to clients with addiction (e.g. homeless individuals or individuals in the justice system). All of these actions were intentional, purposeful attempts to disrupt the exclusionary boundary that held addiction treatment apart from other forms of health care services.

> They're hard to find, those docs who will understand and work with us with this crowd. We are really lucky with the few [physicians] that we have [found] (Safe Harbour)

> With triple aim [population health initiative] one of our [AMH] primary goals is to get many more of our clients with addictions concerns connected to primary care and family physicians (AHS, Senior Manager)

Action that aims to change professional practice to make it more inclusionary is disrupting to incumbents of a mature field. These actions make task boundaries permeable, providing an opportunity for non-incumbent professions to bring expertise to a problem that has long sat within the task boundary of incumbent professions. This has the potential to increase inter-professional competition, especially if not well managed. The actions of AHS managers, and other organizational actors, suggests that disrupting action aimed at making practice more inclusionary was being undertaken cautiously. The creation of the inclusive MHT role suggests a top down attempt to make professional practice more inclusive, however the role was more symbolic of inclusion, as managers recognized that, in practice, inclusionary work was more likely to be achieved when professional staff were co-located and had opportunities to interact. Managers also expected their actions to encourage inclusionary practice to have only local effects. In settings where actors pursued a more inclusive boundary, their actions were focused on encouraging professionals' to explore more inclusionary practice in that particular context.

Pulling addiction treatment into other sectors

In Alberta, actors were pulling addiction treatment into organizations and sectors where, traditionally, addiction treatment had not been provided. For example, Drug Treatment Courts in both Edmonton and Calgary provided an alternate program for individuals accused of crime committed in support of a drug habit. Instead of incarcerating people, these programs offered carefully planned addiction treatment and rehabilitation services. Organizations that helped homeless individuals were also experimenting with models that brought customized addiction treatment into these organizations (e.g. McCullough Center, Safe Harbour). Some of these programs addressed multiple problems simultaneity, for example McCullough Center's program for Perpetual Offenders who were homeless and addicted. Other not-for-profits worked to create 'client oriented' treatment models. Some of these new models required professionals to take traditional addictions treatment practice out of the clinical office setting and into the day-to-day lives of clients (e.g. Servants Anonymous, McCullough Center).

> Now we have social workers [in our facility that addresses homelessness], with the new mandate the social workers are also working with addiction … in terms of program around [addiction] and more of the treatment component (McCullough Center)

> We have AADAC or Alberta Health Services now, addictions counselors actually come into the building and talk with the youth … We used to send [clients] out … we would send them out to [AADAC's] outpatient place … We found better success with the AADAC counselor coming on site and talking with the kids here…. the last couple or three years. (Psychologist, not-for-profit treatment center)

In a mature field with incumbent professions, services are delivered inside the field to a particular group of clients, in a particular way. Boundary disrupting actions encourage professionals to be more inclusive in their practice, to provide other services to addicts in new ways, and to provide addiction treatment to individuals located in other fields. This boundary disrupting work can be direct, for example introducing addiction into drug treatment courts, or indirect, for example dealing with addiction through homelessness or health. Importantly, these boundary-disrupting

actions extend and challenge the task boundaries of incumbent profession and thereby have the potential to motivate actions related to boundary protecting and boundary maintenance. In the Alberta addictions treatment field, this was avoided because boundary disrupting work was contained in local settings.

Temporal Work

Disrupting actions in the field of addiction treatment have not been sudden, grandiose, or immediate. Instead, *small disrupting projects* and *small (re)education projects* have been implemented over time. These small projects initiate disrupting ripples whose effect can be contained. In addition, actors have willingly agreed to defer some projects (e.g. regulatory changes) and have been active in developing future disrupting plans that build upon existing projects. This incremental temporal disrupting work *avoids disrupting shocks and ensures that future disrupting ripples continue* to affect the fields.

Containing disrupting ripples with small local projects

Many of the projects designed and implemented in Alberta were small in scope, although they did not feel small to actors involved in their design and implementation. In AHS, small projects included co-locating different professionals in five community clinics over approximately four years (affecting approximately 24 professional staff). In another zone, co-location was being attempted through attrition hiring, a process that was expected to change the professional composition of clinics over time. In other zones, managers introduced professionals with expertise in addiction into hospital inpatient units and emergency departments, but again only in a few locations and at different times. Some AHS projects introduced professionals with mental health expertise into addiction treatment centers and explored work across boundaries. In other sites, AHS managers explored with their local professional staff, ideas around ‘recovery harm reduction

service' and client-centered treatment approaches identified in Alberta Health and AHS' policy document Creating Connections (AH and AHS, 2011a). Rather than simply imposing new practice models on professional staff, managers of individual clinics moved slowly, exploring over time and with professionals new ideas that would impact practice in local settings. In these discussions, managers respected professional competencies and differences but at the same time maintained an expectation that, over time, professionals would seriously consider how the arrangements and practices of addiction treatment would change.

> We built [our first addiction and mental health co-located clinic] …and then [in another city] … we had a mental health facility and [an] addiction facility … so we said let's increase the number of integrated clinics so we did that one … Now we will be moving into a new facility in [a third city] so that [site] will become another [co-located clinic]. We had an addiction service provider … [in a forth city] …. some space became available at the hospital … so we moved those teams together (AHS Director, describing co-location projects implemented over a four year period)

> We have worked with our main clinics and our directors [to develop] … an expectation that our mental health therapists understand addiction and can provide interventions. This is all new over the last year and a half. We're embracing a new philosophy of care in [this] zone. They've done so in [another zone] related to concurrent disorder recovery oriented services … that's been a bunch of work that we've been doing (AHS, Director)

> I asked each staff member in a team meeting what their definition of harm reduction was and they were all very different … we've started to explore, what does that really mean? Are we making sure that we're giving people all the right information? Are we okay with that? Are we okay if someone wants to come to our program and stop using cocaine and not stop using cannabis? (AHS, Manager)

> We're … creating a treatment plan that's very client driven. (AHS, Manager, talking about working with professionals to change practice in a particular clinical setting)

The projects of other actors were also quite small in scope relative to the size of the sectors in which these projects were implemented. These projects also required substantial effort on the part of actors who championed and designed them. Human Services, for example, identified one site, the McCullough Centre a facility that has long addressed the needs of homeless men in Alberta, as a site where services could be redeveloped to address both homelessness and addiction. Redesigning

services at this site required substantial effort on the part of McCullough Centre senior decision makers, whose vision it was to develop holistic-residential-services. Over two years they achieved their objective, but not before expending substantial effort to gain support from other senior decision makers. The Drug Court is another example of a small project that drew addiction treatment into a new sector but that required substantial time and effort in order to do so. Finally, projects implemented by managers and decision-makers in not-for-profit organizations were also small in scope but required substantial design and coordination efforts. Safe Harbour, for example, developed a multi-faceted program to address homelessness and addiction. This organization developed a community-based residential housing model that did not exclude individuals because of substance use, but rather included them because of their substance use. Substantial work was required to sell this project and to ensure its success. In other not-for-profits, local services were redesigned to incorporate new ideas about addiction. Redesigning these services meant that actors created and nurtured connections with other organizations and re-designed counselling models to address a broad range of concerns including financial management, wellbeing, health, and employment in addition to traditional addiction treatment.

> [Human Services] looked at the McCullough Centre [to provide] an opportunity for [men] that wanted to practice sobriety and get on some kind of treatment plan that could be integrated further into housing … from 2011 to 2013, there was two things going on [at McCullough Centre] … one was the mandate was changing and the other was [infrastructure redevelopment after a fire] … I thought, 'What a perfect opportunity to … really capitalize on an opportunity …'. ... I put together a business case that … provided an optimum arrangement to practice sobriety within, as much as possible, a normalized environment … After a two year serious battle with our ministry, we got the approval to move forward. (McCullough Center, Director)

> [Harbour House is] in a residential neighborhood [that] was very scary to me. I was thinking, 'Oh my god what's going to happen?' [I had to do a lot of work to convince communities this would work] … [Now] … I would never do a model that wasn't in a residential neighborhood (Safe Harbour, Executive Director, describing the new Harbor House model)

> Ultimately, many disrupting projects implemented in the field of addiction treatment were

small in scope, although they required substantial effort on the part of managers, decision makers, and incumbent professions. These projects created local disrupting ripples in the present time and in contained space. In a mature field with professional incumbents, these projects achieved local disruptions and served to increase variation in the field without shocking the field broadly. By creating local ripples and minimizing how far ripples flow, disrupting actors reduce the chance that field incumbents will engage in neutralizing action that will suppress the disrupting ripples. Small project with disrupting ripples are also a way to conserve disrupting energy in the field. Actors doing this disrupting work need only pay attention to local settings, allowing them to extend their limited energy on the not-insubstantial challenges they face in operationalizing small projects. Importantly, the adjective *small* is used in relation to the size and scope of these disrupting projects, not to imply that these were trivial or inconsequential.

(re)Educating professionals in local settings

Professionals receive specialized and focused education that teaches them to diagnose, reason about, and treat problems in a particular way. A particular type of disrupting action engaged in by actors in the Addiction treatment field was to (re)educate incumbent professionals of the addiction field, and other professionals, by introducing new ideas about addiction. Incumbent professionals attending the AFWI symposium were (re)educated about the connection between brains and addiction. Expert presenters talked about addiction as a brain disease and presented alternative models of addiction treatment, including physician-addiction treatment models, trauma based counselling models, and family counselling models, all of which science showed had better outcomes compared to traditional addiction treatment (Observation field notes). Secondary data from the AFWI Evaluation (2014) suggests that professionals were applying the knowledge they received during (re)education in their day-to-day practice. Other non-profit actors also (re)educated

professionals about addiction and the kinds of services required by individuals with addiction. StreetWorks (a non-profit organizations), for example, provided in-services and placements for students of medicine, nursing, corrections, social work, and ambulance services, targeting the next generation of professionals who would be interacting with individuals with addiction. StreetWorks also provided education and in-services to professionals already interacting with individuals with addiction, focusing on emergency services professionals. Safe Harbour (another non-profit) also educated nursing, social work, and other students through practicum placements and tours, and was exploring (re)education opportunities with the local hospital.

> Survey respondents (35%) have changed their day-to-day interactions with patients or clients … this percentage was significantly higher for those in the addiction and mental health and general health fields (49% and 45%) … a family doctor explained, "One of the things I've changed in my practice is the questions that I ask." She went on to describe what she considers are the priorities for each patient and how she incorporates targeted questions around addiction and mental health as needed. Other practitioners have begun to routinely refer their patients to AFWI materials. (AFWI Evaluation, 2014: 28)

> We have lots [of contact] at the college, the nursing department, social work department. They come and do tours … [General practitioners'] residents come here. [Harbour House has] new residents every month, they come and spend a day at the Harbor … which is awesome, to get those new doctors. (Safe Harbour)

(re)Educating actions are disrupting to a mature field with incumbent professions. First, they interrupt how a few professionals (incumbents and others) in particular spaces and at particular times interact with individuals with addiction, disrupting practice in local settings. Local (re)educating actions do not impose broad practice disruptions on field incumbents. Instead, this kind of action sets in motion small ripples that increase variation in the field without disrupting the majority of incumbents. While the effect of this kind of disrupting action is difficult to see, the hope of actors engaging in this kind of action is that disrupting ripples will accumulate over time.

Avoiding disrupting shocks and ensuring future disrupting ripples

In the field of addiction treatment, actors were engaging in real time actions to disrupt

arrangements and practices. However, in addition, some disrupting actions were deferred to the future, *avoiding disrupting shocks in spaces that were highly contentions* and *ensuring that disrupting ripples continued in the future*. With respect to the former, in the field of addiction treatment, some incumbent professions were regulated while other occupational experts were not. With the creation of AHS, and the drawing together of broader group of professions, the problem of regulated verses non-regulated reared its head because un-regulated occupational experts' scope of practice was constrained versus similarly educated regulated professionals (e.g. regulated social workers/counsellors versus un-regulated addiction counselors). An exception issued by the government allowed actors to defer taking action in relation to this contentious issue. Under the exemption, new addiction counsellors were required to obtain membership in a professional association, however incumbent addiction counsellors were allowed to continue to practice under their previous scope-of-practice and provide 'restricted practices'. Five years after the first exemption the government extended the original exemption, again deferring the need to deal with this contentious issue. Actors in the field recognized the importance of dealing with regulation at some point, but also were quite willing to set the issue aside for as long as possible.

> … the issue of the regulation versus unregulated has in the last year become a significant enough issue that we are going to start to have some really critical conversations and making some decisions about what can be integrated and what can't. (AHS, Director).

> The exemption for [AADAC occupational experts] … expired in March of this year … There was a lot of scurrying around … what are we going to do? Because under the exemption they were able to do restricted activities … but with that exemption expiring it was like okay this is a problem … [there was talk about] ensur[ing] that regulated providers that could be the umbrella provider … that is very dangerous [because of domination] … [in the end] they were given an extension on the extension. It still needs to be resolved but I don't know how it will be resolved. (AHS, Director).

With respect to the latter, actors in the field planned disrupting projects for implementation in the (near and far) future. Some future planning was quite pragmatic, with actors planning how future disrupting might build upon present day disruptions. For example, within AHS, future planning

included discussions around how integration of addiction and mental health services would proceed. In other spaces, future planning work was more strategic and was focused on identifying needed but absent connections between groups and organizations and determining how to make these connections to continue the distribution of new ideas about addiction and addiction treatment. Finally, other planning work was very conceptual and systemic. The planning activities undertaken by the Human Services and Education sectors, for example, included identifying the many different social groups for which addiction is a problem and considering how systems of supports might be developed, within and between sectors. Regardless of the nature of the planning work, actors recognized that patience was required as, more often than not, implementing these future projects and seeing systemic disruptions would require many initiatives to proceed and gain traction (e.g. SCN, Primary Care Networks, and Human Services).

> Since 2012, there's been some serious effort from directors [managers, and frontline staff]… around how do we actually integrate … it's not enough to say that we're integrated because we're all under one system, or we're integrated because we have an addiction counselor in this mental health clinic. That's not integration either … Part of the shift over the last two years is about putting all the managers and front line staff together to say, 'Okay so we need to figure out something. We need to do it differently'. (AHS, Manager)

> As a second step [our planning is] looking at … homeless, bullying, family violence, sexual assault, AISH, people with developmental disabilities … those Human Services are all part of our file in government. All of those have addiction mental health in common. We want to develop an internal system of supports linked to the external clinical system of Alberta Health Services. (Human Services)

> We learned a lot about how to work in the primary care world [from our other projects]. We've thought about whether alcohol should be part of what we bring to primary care … [but] we have not [set a path forward] … we're waiting on a couple of things. There is going to be the launch of a primary care strategic clinical network in the spring. So it may be very good timing to then begin thinking about how we work with primary care in a different way … [PCNs are] all individual businesses and you have to work individually with [each one] … it might be that … once there's a network there will be a more integrated way to think about that work. (AHS, Strategic Clinical Network)

Deferring action on contentions issues (e.g. regulated versus non-regulate professions and expert occupations) was disrupting to the addiction treatment field and its incumbent professions.

Deferred action helped move other disrupting actions forward in the here and now as, with the exemption in place, managers were able to introduce addiction counsellors into healthcare settings without narrowing their scope of practice, an important consideration because any managerial action that served to narrow professionals' scope of practice would likely have been met with resistance. The deferral of scope of practice discussions granted time for professionals themselves to explore each other's work and contribution to addiction treatment without positioning any one profession or expert as more 'professional' than the other. Future planning activities are also disrupting actions because actors undertake these with purposeful intention in order to ensure that mature fields continue to move towards some alternate future state. Future planning actions are an important type of disrupting action in a mature field with incumbent professions because they avoid creating disrupting shocks in the here and now, in particular avoiding larger shocks that field incumbents would react negatively to and actively suppress. Future planning actions allow actors interested in disrupting a mature field with incumbent professions to incrementally layer disrupting ripples over time, in the process sustaining movement towards the alternate future state.

Summary and Connections to Part 2 Study

In Part 1 of my study, I explored the question, *how do actors disrupt a mature field with incumbent professions*? My findings show that actors were disrupting the Alberta addiction treatment field through different kinds of disrupting actions that I aggregated into three forms of disrupting work: complexifying work, boundary work, and temporal work. These findings are summarized in *Figure 2: Disrupting work in a mature field with incumbent professions*.

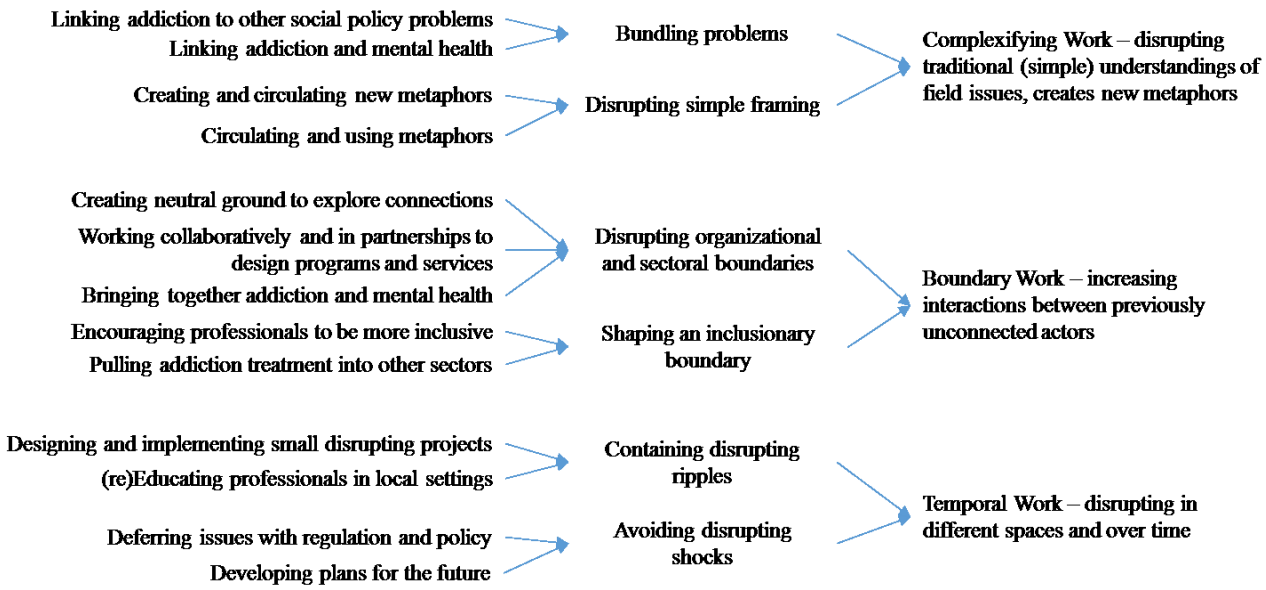

Figure 2: Disrupting work in a mature field with incumbent professions.

Complexifying work includes bundling the field's problem – addiction – to other social problems and other health concerns, and includes creating, circulating, and using new metaphors that disrupt simple problem framings. Complexifying work is disrupting to a mature field with incumbent professions because it creates complex imagery about a field's issue and because it requires incumbents to respond in ways that show how their arrangements and practices fit within the more complex imagery. *Boundary work* is a second form of disrupting work, and includes actions that are disrupting to organizational and sectoral interactions and actions that shape an inclusionary boundary around the problem of addiction. Boundary work is disrupting to a mature field with incumbent professions because it pushes incumbent professions to interact with different actors and because it pushes professions to practice in a way that is inclusive. Finally, the third form of disrupting work is *temporal work*. Temporal work arises from the design and implementation of small projects that contain disrupting ripples and from deferred disrupting actions that include the deferral of contentious issues and the development of future disrupting plans. Temporal work avoids large disrupting shocks in the here and now and ensures that disrupting ripples will continue

to disrupt the field in the future.

The connection between the Part 1 study that explores the disrupting work of field actors and the Part 2 study that explores how actors disrupt professional practice is as follows. Some of the small projects created by field level actors to create local ripples are projects that intentionally attempt to disrupt professional practice. Insights from empirical studies (e.g. Barley, 1989; Bechky, 2003; Kellogg, 2012) imply that disrupting professional practice will be very difficult. It thus seems likely that specific actions will be required to disrupt professional practice. In the Part 2 study, I explore a community clinic where addiction and mental health professionals were collocated to develop integrated and collaborative practice. Clinic A represents a small disrupting project created specifically to disrupt practice.

CHAPTER 4: FINDINGS (PART 2): DISRUPTING PROFESSIONAL PRACTICE

In this section of Chapter 4, I present the findings from Part 2 of my study in which I explored the question, *how do actors disrupt professional practice?* Professional practice refers to the activities and routines that professionals enact in their day-to-day professional lives. Practice belongs to social groups not individuals (Whittington, 2006) and professionals learn practice as they are socialized into professions. Traditional addictions treatment practice reflects institutionalized values: it emphasizes independent autonomous practice; it positions the professional as the expert problem solver; and, it respects hierarchical and task boundaries between different professions. In Clinic A, traditional practice had been disrupted and a more integrated and collaborative practice had been developed. In *Table 5: Comparing Traditional Additions Treatment Practice and Clinic A Practice*, I present a summary of traditional addiction treatment practice and Clinic A practice. *Figure 3: Longitudinal disrupting to clinic practice* shows disruptions over time.

	Traditional Addiction Treatment Practice	**Clinic A Practice**
Clinic Space	No co-location, no collaboration. Few interactions between different kinds of counsellors, no interactions with mental health. Addiction Counsellors, Social Workers, Psychologist. Psycho-Social-Behavioral Model	Co-location between addictions and mental health, formal and informal interactions between clinic professionals on a daily basis. Professionals work together to help clients. Addiction Counsellors, Social Workers, Psychologist, Psychiatrist, Registered Nurse. Psycho-Social-Behavioral Model + Medical Model.
Assessment	Addiction Counselors complete intake for clients. If client has mental illness, refer to mental health. Client completes referral. Professionals conduct assessments using the AADAC Substance Abuse and Gaming Assessment tool (SAGA). Professionals do not asses mental health issues.	Clients are booked into the next available assessment slot, no matching of client to clinician based on problem. 0-18 months - professionals do joint-assessments using SAGA (addiction) and HONOS and Mental health assessment tools. 18-30 months - professionals conduct solo assessments using combined assessment tool developed in the IPC. 30 months + professionals screen clients to addiction / concurrent / mental health categories, match problem classification to clinician for complete assessment
Case Conference	No case conferencing	Case conferencing adapted to support clinic practice. Clients presented using Strength Based Presentation Form (SBPF). Open group discussion after every case. Professionals provide support for each other, and discuss resources that might be useful for clients. Managers provided clinical input.

	Traditional Addiction Treatment Practice	Clinic A Practice
Psychiatry Consultation	Clients referred to psychiatrists, minimal direct contact between addiction experts and psychiatry.	Clinic professionals are primary treatment/counselling providers. Clinic professionals refer directly to psychiatry for specific concerns, and discuss concerns with Psychiatrists in advance of consultation. Clinic professionals participate in psychiatry consultation. Psychiatrists' recommendations may or may not be incorporated into treatment.
Counselling and Treatment	Behavioral model - motivational interviewing, stages of change, some cognitive behavioral therapy.	Behavioral model plus medical model. Professionals continue to work in scope with traditional tools. Professionals are more aware of different treatment options. Professionals are comfortable sourcing alternate treatments from others in the clinic. Professionals make client referrals within the clinic and continue to work with clients, monitoring substance use and mental health concerns.
Tools	Addiction experts chart in an addiction specific electronic charting program (ASSIST) and use a substance abuse and gambling assessment (SAGA) tool.	Shared client file available to all clinic professionals. Information in ASSIST, ARIMS, and eClinician is printed and is included in shared client chart. Joint-assessment form created. Strength based presentation form adapted for clinic use. Plans to redesign discharge forms, treatment planning forms.

Table 5: Comparing traditional addictions treatment practice and Clinic A practice.

Disrupting in Clinic A	6mo	12mo	18mo	24m	30m	36m	42m	48m
Configuring space								
Assessment	Joint assessment			Solo assessment				
	Professionals choose who leads client treatment			Professionals are responsible for clients they assess			Talk about 3 stream model	
	Separate addiction & mental health assessment tools					Joint-assessment tool		
	All clients assigned to first available assessment slot, no assigning of client to clinician type							??
Case conference	MH model	Strength Based Presentation						
	Present new intakes only						Present new intakes + difficult treatment clients Introduction of trauma informed practice	
Psychiatry consults	Staff sit in, and participate in, psychiatry assessments							
Counselling	One on one counselling and treatment continues Client let treatment choices and treatment goals Ongoing attempts to bring new ideas and knowledge to treatment							
Charting	Separate files	Combined hardcopy files		Merged and integrated hardcopy files				
	Separate electronic records		Problems with separate identified and brought the senior management attention				Initial discussions to electronic file systems	

Figure 3: Longitudinal disrupting to Clinic practice.

How Do Actors Disrupt Professional Practice?

In this section, I describe the disrupting actions that actors of Clinic A – professionals and managers – engaged in that served to disrupt traditional professional practice. I draw attention to actions that disrupted space, tools, activities, and relationships and that aggregate to three types of disrupting work - *configuring work*, *adapting work*, and *boundary work*. Disrupting work arose from the purposeful and intentional actions of managers and professionals who strove to disrupt traditional practice, in the process developing integrated and collaborative practice.

Configuring Work

To configure something is to shape something or put it together in a particular form or way (Oxford, 2015). In the clinic, senior managers configured *clinic space* in a particular way to support integrated and collaborative practice for addictions and mental health services. Also in the clinic, managers configured *staffing ratios* and the *professional-managerial relationship* in such a way to support integrated and collaborative practice between professionals.

Configuring space

Clinic A occupied custom designed space in a new community clinic. Senior managers had been involved in planning and designing Clinic A space from the earliest days, always with the intention of developing space that would co-locate services. Because planning had commenced prior to AHS, early design provided separate space for AACAD and the Health Region's file storage and servers, as required by law. After the formation of AHS, senior managers insisted on design changes, consolidating file storage and support spaces and in the process eliminating the few spaces that separated addiction and mental health. All full time professionals were assigned to offices that were the same size and were identical in furnishings and décor. Office assignments ensured that professionals with expertise in addiction were located between professionals with

expertise in mental health. Psychiatrists, who provided consultations on a scheduled weekly basis, occupied an interior office with no window. The configuration of space and offices supported frequent formal and informal interactions between professionals. These interactions were also facilitated by an 'open-door policy'. During my time in the clinic, I observed that professionals only closed their office doors when they were engaged in one-on-one counselling with clients. At other times doors were open, even when professionals were charting or making phone calls. Managers' offices were off site, and professionals stated that because they were not subject to constant managerial oversight they were comfortable spending time with each other, learning about each other's work, and seeking advice from each other.

> The intention was to co-locate our services. So all of the planning, all of the design, all of that, was done with the intention to co-locate mental health and [addiction services]. It was always going to be a co-located clinic. (Director, mental health)

> We strategically placed the offices – a counselor, a mental health therapist, a counsellor, a mental health therapist - … not just counsellors down there and mental health over here. We purposefully … set it up that way [we paid attention to] … integrating them in the physical setting itself. (Manager, addiction services)

The specifically configured clinic space was disrupting to traditional professional practice. In particular, it was disrupting to independent practice because it co-located professionals and encouraged them to explore how practice might be connected. It was also disrupting to task boundaries because two problems were brought together in integrated space. The clinic space reflected no separation between addiction services and mental health services and supported the integration of artifacts that could have reinforced separation, for example client records. The space was also disrupting because it did not reflect hierarchical differences between professions. The clinic held no identifiers of professional orientation or hierarchy. Additionally, the space reduced hierarchy because all full time professionals occupied identical offices, and the higher status psychiatrists were located in the least desirable office. Even the shared administrative space made

visible professionals' schedules and work activities, reinforcing equality. Indeed, the specially configured space contained no detritus of traditional practice; instead, it provided neutral space in which to explore collaborative, integrated practice.

Engineering the staffing model

The staffing model within Clinic A was intentionally engineered to support integrated collaborative practice. When Clinic A first opened, managers ensured that the professional staff complement was balanced between experts in addiction and experts in mental health. Managers of Clinic A also had to manage regular staff attrition and leaves-of-absences. Clinic A managers had carefully considered the type of professional staff they wanted to bring into the clinic and had engineered an interview approach that they felt would bring out important behavioral as well as technical competencies. I interviewed three new professional staff hired into Clinic A using this new approach. Each of the new staff was supportive and enthusiastic about Clinic A practice, and the existing professional staff were also pleased with the new clinic members.

> The difference with [the Clinic] as a departure from [other attempts to integrated addiction services into healthcare] is that the weighting of staff was balanced, so in the [Clinic] the staff complement … is evenly distributed .. two addiction counselors and two mental health therapists … [the Clinic] (Senior Manager, mental health)

> [We, the two clinic managers] are starting to make joint decisions that were not legacy ones from other managers … we get to choose these next two staff and we really went for fit. … [We] look at technical competencies and behavioral competencies … we have had chats [about] want[ing] behavioral competencies because technical competencies we can teach. (Manager, addiction services)

In Clinic A, the staffing model was specifically configured to support integrated and collaborative practice. The staffing model put in place was disrupting to traditional professional practice because it brought into the clinic professionals who were particularly open to exploring practice that combined elements of addiction treatment practice and mental health practice. In particular, the professional staff of Clinic A were very open to the idea of disrupting task

boundaries and to moving away from the idea that professional practice should be focused on *a* particular problem. The configured staffing model also disrupted the value of independent practice, allowing professionals to explore the value of multiple expert opinions. Importantly, while managers downplayed the importance of technical expertise, in reality their interview questions and research of prospective clinic members ensured that these individuals were technical experts in addition to experts open to exploring different ideas. Thus, the configured staff model upheld the value of independent expertise even as it elevated the value of collective practice.

Advancing a collegial relationship between management and professionals

Professional practice is traditionally free from oversight and influence, explaining the confrontational interactions often depicted between professionals and managers when professionals perceive that management becomes involved in professional practice. In Clinic A, however, managers had advanced a collegial relationship between themselves and the staff professionals. They had done so by involving professionals in the disrupting of practice, by themselves contributing to disrupting activities and tools of practice, and by holding professionals to the disrupted activities and tools. In Clinic A, managers facilitated discussions and spent a lot of time 'shifting paradigms', shifting professionals' attention away from traditional notions about practice. Managers encouraged professionals to identify activities of practice that needed to be disrupted. They also supported formal cross-training activities, encouraged informal interactions between professional staff, and encouraged professionals to think differently about their practice. Finally, managers kept professionals honest to the disrupted activities and tools used in clinic practice. In case conference, for example, managers pushed professionals to use the strength based presentation form and language and ensured that discussion took place for most clients. I observed, in case conferences, that managers typically asked the first question after each presentation and that their

questions were often clinical in nature. I also observed that after managers asked a question, other professionals joined into the discussion. I did not observe professionals' reacting negatively to managers' involvement in clinical discussions, nor did I observe any discussion involving only a manager's question. Ultimately, managers had demonstrated to professionals the value of having managers involved in disrupting work.

> We spent a lot of time in the first year and a half trying to shift paradigms … and trying to get people on board and engaged … [not saying], 'I'm a mental health therapist [or addiction counselor] this is my deal, I don't know what you do but this is my job description'. That's why we do the in-services, and that is why we did the retreat team building days. (Manager, addiction services)

> I'm constantly reminding them [professionals] take it back to the basics … bring it back to empathy, rapport building, being non-judgmental. Just sit with [clients] and give them the respect – lots of people are very prescriptive with clients, go do this, go do that – we don't have to tell them what to do … they just need a safe place to come for a while before we start battling through that heavy duty stuff. (Manager, addiction services)

> You see us all struggling in [case conference] … [trying to] use this tool [the strength based presentation form]. We struggle with the tool … We're forced to do strength based talk when the manager is in the room. (Counsellor)

Another way that managers advanced a collegial relationship was to shelter professional staff from external contradictions and inattention. Although senior managers were adamant that Clinic A had a clear mandate, outside of the clinic walls the Addiction and Mental Health Department continued to explore how to bring together the two organizational entities (see Part 1 Study). Clinic A managers recognized that they, and clinic professional staff, were receiving contradictory messages from senior management, and they spent a considerable amount of time communicating to ensure that a consistent message was delivered within the walls of the clinic. In addition, Clinic A managers recognized that professionals often felt that their work in the clinic went unrecognized. Managers made similar comments themselves, suggesting that the organization was rather inattentive to the clinic and did not recognize the improvements and changes that had been made.

> [The other manager] will get different communications from … the mental health director. I'll

> get different communications from … the Addictions director … we are constantly checking with each other, 'What did you hear? What did I hear?' (Manager, addiction services)
>
> The staff feel frustrated, they've … come to me and said you know if we are truly wanting to be integrated we need to feel support [from the organization] and we feel like it is not there. (Manager, mental health)

I observed that managers consistently reinforced to professionals that the work they were doing in the clinic was important and was being seen. Managers started each case conference with an update about 'integration' and how learning from the clinic was being distributed in the organization and more broadly. In one case conference, a manager described a presentation she had given about the clinic at a national conference on the integration of addiction and mental health. Managers also talked about how they were introducing ideas from the clinic (e.g. the strength based presentation tool) into the other clinics they managed. Managers kept professionals up to date about organizational plans for the clinic, letting them know that the clinic had been chosen as a pilot site for an integrated, electronic health record. Finally, managers continued to bring new ideas about addiction and mental health to the staff professionals encouraging them to discuss how new ideas might be incorporated into practice.

To advance means to go forward, to make progress, and to continue a process of development. To advance a collegial relationship between managers and professionals means to develop a supportive relationship that helps professionals practice in an environment that is being disrupted. Within a collegial relationship, professionals have a level of comfort with management introducing disruptions, recommending different ways of engaging with clients, and pushing professionals to practice differently. The collegial relationship itself is disrupting to traditional values of professional practice, in that it disrupts autonomy, but also it helps create an environment in which professionals can safely start to explore disruptions to traditional practice.

In summary, Clinic A configuring work put together space, staffing, and relationships in ways

that were disrupting to traditional addictions treatment practice. Configured physical space minimized detritus and fostered new interactions between professionals that disrupted traditional interactions. The engineered staffing model ensured a balanced staffing complement and the new hiring process ensured members of the team had important behavior competencies in addition to technical competencies, disrupting the traditional emphasis on technical expertise and elevating the value of diverse expertise in practice. Advancing a collegial relationship between management and professionals disrupted the traditional confrontational relationship between managers and professionals, helping professionals be open to management's involvement, insight, and contributions to disrupting traditional practice. Ultimately, configuring work is disrupting to many of the traditional values of professional practice, for example values that underpin independence, task boundaries and hierarchy, supporting the disrupting of traditional practice and the exploring of alternate practice models and activities and tools.

Adapting Work

In Clinic A, managers and professionals disrupted and adapted activities and tools of traditional addiction treatment and activities and tools of mental health practice in support of integrated and collaborative practice. Adapting work involves bringing together traditional activities and tools of practice, in the process making them more suitable for a different practice.

Redesigning activities of practice

In the clinic, assessment and case conference were two activities of practice that had been adapted to support integrated and collaborative practice. These activities had been a part of addictions treatment practice and mental health practice, respectively, but had been specifically re-designed to support Clinic A practice.

Assessment

In traditional addiction treatment practice, the first interaction between client and professional is assessment. During assessment, professionals ask questions that explore clients' substance abuse using a substance abuse and gambling assessment (SAGA). One-on-one assessments are the norm because assessment is critical to building rapport and trust between professional and client. In traditional practice, if professionals suspect mental illness they refer clients to mental health.

In Clinic A, assessment was disrupted and re-designed to support integrated, collaborative practice. As most clients were presumed to have both addiction and mental health issues, clients were assigned to the first available professional and there was no matching of client to clinician. In addition, for the first 24 months of clinic operation counsellors, social workers, psychologists, and nurses conducted joint-assessments. Professionals would together ask questions of the client and then would step out and discuss the assessment. Professionals found joint-assessment instrumental in helping them become more aware of each other's understanding and approach with clients. After 24 months, managers discontinued joint-assessment on the understanding that professionals were competent to assess clients' mental health and addiction issues. Clients continued to be assigned to the next-available assessment slot, and professionals were still expected to be responsible for any clients they assessed, working with other clinic professionals if clients needed particular treatments that were out of professionals' task boundaries. At approximately 30 months, professionals began to use a joint-assessment tool, developed in house, that brought together critical addiction and mental health assessment questions.

> Prior to the last six months they were doing intake together … an addictions counselor and a mental health therapist would see a client for the first time together. … After the client left there was a lot of debriefing that went on. 'Did you catch this, did you catch that? Did you realize this was a symptom of whatever, this medication could have affected how this client could have presented' … A lot of cross training that happened there. We've since stopped that I think around about six months ago. Just because we felt they were cross trained enough to

be able to do intakes on their own. (Manager, mental health)

> We said how do we make individuals more concurrent capable in assessment. So we shadowed every intake that came in for quite some time, the first year and a half [clients[… got an addictions counselor and a mental health therapist in intake … [professionals] would both be doing their thing, taking turns … a joint assessment. (Counsellor)

In the Clinic, the assessment activity had been disrupted and adapted to better suit desired practice. First, assessment no longer supported the independent exploration of a particular problem. Instead, assessment became an activity during which professionals with expertise in addiction could also legitimately explore mental health issues (and vice versa). Second, the re-designed assessment activity disrupted traditional practice because it supported professionals working together, disrupting independent work, but in a non-confrontational way.

Case conference. Traditional addictions treatment practice did not include case conferencing, an activity of mental health practice. In the clinic, managers instituted a weekly case conference that had some elements of traditional mental health case conferencing (professionals met to talk about clients and treatment plans), but which had been re-designed to support clinic practice. Case conference started with managers providing an administrative update about the clinic or the organization, addressing policy changes, new directives from senior management, upcoming training (e.g. trauma based counselling), and new staff. During these updates, professionals and managers engaged in rather heated discussions about directives that professionals' perceived would negatively affect clinic practice. They also engaged in thoughtful discussions around new ideas about addiction, mental health, and clinical practice (e.g. trauma informed counselling and sex addiction) and about how to incorporate these into clinic practice.

After the administrative update, managers would ask, 'Who wants to go first?' opening the table for client presentations. Any of the professionals might start presenting (typically the professional with the most new admissions). Professionals presented clients using the clinic's

strength based presentation form (SBPF), drawing out clients' goals and strengths. (A detailed description of the strength base presentation is located in the Boundary Work section). Professionals next shifted to presenting detailed client history, telling stories that touched on clients' history of abuse, history with trauma, family/caregiver arrangements (past and present), relationships (past and present), housing, employment, physical health, financial issues, and involvement of other agencies (e.g. Children and Family Services, Justice, Human Services). Professionals also described what they knew about clients' past interactions with addiction services and mental health services. Finally, at the end of each presentation, professionals would provide details about mental health diagnoses and particulars of substance use. During presentations, other professionals would interrupt with questions, and these would be addressed as they arose.

> When we started [the Clinic] we said ok [the case conference] cause [mental health still had to do it. So this was how do we make our two businesses fuse … we were using for a long time the old mental health case conferencing [approach]. And then we said, 'No, let's switch gears here … let's get away from this diagnosis, problem based case conferencing tool. (Manager, addiction services).

> Before in case conference we jumped into the client's history the problems … The structured set of [strength based] questions puts the focus more on the person's strengths their goals, things that they are good at like our connection with the person, which is good. But … if you follow just that then you …don't know why the person is coming in, because the person is coming in because they have problems … let's talk about the problems … so we made a modified version of [the strength based form], and we go through … and answer all the questions, but then we have a segment where we go into the dirty details about their drinking, abuse … so that way [case conference] is also very much focused on issues. (Counsellor)

> If [we] are really struggling with the strengths piece [in case presentation] we will move on we will talk about [the client] story and then collaboratively we will come together and be like, well you mentioned this [and help identify a connection]. (Social Worker)

At the end of each presentation, the professional would outline a treatment plan for the client and a manager would ask, 'Does anyone have any recommendations or suggestions?' Approximately half of the presentations involved group discussion. A manager would often start the discussion by asking a question, usually quite clinical in nature. This opened the door for other professionals to

join in and ask questions, usually associated with their professional expertise. Nurses, for example, would ask questions about medications, social workers about housing or relationships. Professionals also asked for, and offered, information about clients' past treatment, for example saying, 'I know that client, I worked with him/her before,' or, 'I think I know someone who worked with that client.' At times, questions would lead to a general discussion about medications, treatment options and resources, and health issues.

> At case conferences … the [professional] will present their initial assessment of the client and then ... after they present, we open the floor up for recommendations. Even during presentations, the other professionals are able to ask questions, to dig deeper around medications, or who is their psychiatrist, or whatever. (Manager, mental health)

> On Tuesday morning, we come in and we have our file folders, and I'll say I'm presenting. … I will give a brief synopsis and overview of what we talked about, what [the client's] issues are, what I think is a treatment plan and then the other disciplines will … give their options, what is available for treatment or if there are different avenues or angles. (Nurse)

> [At case conference] we present any new intakes … why they came here, what's going on with them. Trying to portray as much as you can [about] who this person is and what is going on, and then what we planned or what kind of treatment plan we came up with together. Then the other team members will ask questions and work around different things you [didn't] necessarily think of … or if they just need additional information to wrap their heads around … if they have any suggestions they throw [these in]. (Social Worker)

The re-designed case conference activity differed from mental health case conferencing because psychiatrists were not involved, a strength-based presentation was used in place of a clinical (problem oriented) presentation, and professionals and managers were encouraged to ask questions and offer insight at any time during the presentations.[2] In addition, each case conference started with an administrative update, merging administrative (managerial) content and clinical content. The re-designed case conferencing activity was disrupting to traditional addiction treatment practice. It required counsellors, social workers, and psychologists to present clients to a non-peer

[2] Traditional medical case conference includes a presentation of clients' symptoms and a presentation of provisional diagnosis and treatment plans. Psychiatrists attend, with their presence influencing the interactions of the other professions, and with other professionals typically deferring decisions and responsibility to psychiatrists. Management's participation is minimal.

group of professionals, which had not been an element of traditional practice. It also required professional to talk together about clients, clients' presentations, and treatment options, all interactions that had not been normal in traditional additions treatment practice. Finally, it disrupted how professional talked about their clients, shifting language away from problems and towards clients' strengths and goals.

Re-designing tools used in practice

In traditional addiction treatment practice, counselors, social workers, and psychologists used profession specific tools, for example, addiction experts used an electronic charting program called ASSIST and a substance abuse and gaming assessment (SAGA). Psychiatrists and nurses likewise used their own charting and assessment tools. In the clinic, however, traditional tools had been re-designed as shared tools, for example a shared client record and a joint-assessment tool had been developed. At first, the shared client record consisted of a manila folder with printouts of clients' addiction services charts, a manila folder with printouts of clients' mental health and healthcare charts, slotted together in a third manila folder. After about 18 months, managers and professionals developed an integrated chart in which they collated individual pieces of clients' addiction and mental health charts in one folder (including psychiatrists' assessments and recommendations). Professionals and managers had also worked together to develop a joint-assessment tool, examining mental health and addiction assessment tools and drawing from these critical questions for all clinic professionals to ask during assessment. Re-design of tools was ongoing and where tools were not yet integrated, professionals helped each other access information, for example, social workers, counsellors, and psychologists would access the addiction electronic charting system on behalf of psychiatrists or nurse (and vice versa).

> We have in the last year have an integrated chart, finally. … Because … addictions has an electronic chart and [mental health has] a paper chart … the electronic chart has to be printed

off and then put in to [the integrated chart]. (Manager, mental health)

> They [professionals and managers] had started … looking at our addictions assessment tool, looking at the mental health assessment tool and saying, 'Ok what is essential, what are the main components that really guide our work?' And taking those and trying to put them together in a way that makes sense and a way that is productive. (Social Worker)

Re-designing tools helped develop tools that were familiar to the professionals in the clinic and tools that were more suitable for integrated collaborative practice. The re-designed tools sometimes made activities of practice easier for professionals (e.g. the joint-assessment) and sometimes made them harder (e.g. the joint client file). However, in using these re-designed tools, professionals were constantly reminded that addictions and mental health were linked issues justifying the disrupting of traditional practice and the development of integrated, collaborative practice. Even the action involved in redesigning tools was helpful in disrupting traditional practice. Professionals saw value in re-designing tools and worked together to do so, reinforcing the values desirable in the disrupted clinic practice. The effort professionals put into re-designing tools was reflective of the effort they made to disrupt practice more broadly.

In summary, adapting work includes re-designing traditional activities and tools of practice so that these are more conducive to the desired practice. Adapting work pulls out particular activities and tools of broader practice, purposefully re-designing these. In the clinic, re-designing activities and tools of practice was disrupting to traditional addictions treatment practice. Re-designing activities made them more suited to integrated collaborative practice because the re-designed activities brought together different professionals to explore clients' problems and to work across task boundaries. Adapting work is incremental and additive if undertaken thoughtfully, as it is slowly disruptive of traditional practice and of the values that underpin traditional practice. Over time, as more activities and tools are adapted, adapting work builds, reinforcing disruptions made prior and introducing new disruptions to professional practice.

Boundary Work

In traditional addictions treatment practice, the labels carried by professionals with expertise in addiction – psychologist, social worker, and counselor – separate these professionals from experts in mental health – psychiatrists and nurses, and serve to demark task boundaries and hierarchy boundaries. As well, the differences in knowledge between professionals and clients contributes to a boundary that positions professionals as expert problem solvers and clients as treatment receivers. In Clinic A, disrupting actions categorized as boundary work contributed to disrupting these boundaries.

Trivializing task boundaries

In professional practice, different professionals are responsible for particular actions aimed at resolving particular problems. Professionals with expertise in addiction, for example, are responsible for independently assessing clients' addiction related problems and then applying their professions' models to those problems. These daily activities take place within a *task boundary* and activities that do not belong within the task boundary do not form part of practice. Actions in Clinic A trivialized task boundaries, making them inconsequential for some activities of practice.

As described previously, adapting work had redesigned some of the central activities of professional practice in Clinic A. These adapted activities created opportunities for professionals to interact and practice across task boundaries. For example, random assignment of clients at assessment meant that addiction experts had to assess clients with mental health problems, and vice versa. Joint assessments required professionals with different task boundaries to work together and explore clients' problems together, as did case conference. In addition, in the clinic, professionals frequently turned to one another for help if they were having a difficult time progressing with a client and were not sure where to take clients' treatment. In these informal interactions,

professionals would turn to whomever was available to discuss treatment options.

> Between addictions and mental health there was a lot of going back and forth going to each other's offices saying, 'What do you think?' Almost every person you saw, you came to see your neighbor next door to say, 'Hey I have [this question or problem]...' (Nurse)

> I know that I have the luxury of … going to go down the hall and [talking to other professionals] about this client saying '... This is what we planned together do you think I am on the right track?' … just brain storming. I would do that with Addictions, I have done that lots, with mental health, [the nurse]. (Psychologist)

In the clinic, effort was made to cross-train professional staff, introducing them to the tools and activities of other professions. Regulated scopes-of-practice limited how far cross-training could influence professionals' actual work (i.e. addiction professionals could not apply models from mental health). However, while scope-of-practice limited the application of knowledge obtained during cross-training, it could not limit professionals' attention to problems and solutions outside of task boundaries. Social workers and counsellors, for example, both spoke to paying more attention to mental health issues and medications. In the clinic, while applying solutions was constrained by task boundaries, problem identification, problem exploration, and problem reasoning was not. As professionals became increasingly comfortable with both mental health and addiction, and with solutions to these problems, task boundaries trivialized.

> I have a client who is talking about switching jobs and she's so conflicted … it's causing her so much stress. I'm using some [motivational interviewing, and addiction services tool], and I'm not very good at it yet …but I've learned a few things … like the pros of staying, pros of leaving, like looking at all the sides … (Nurse)

> I started working with ... a border line woman ... towards the end [of the counselling session I said] 'has anyone ever talked to you about what is border line personality?' and [she said], 'no what's that' and we read off the document … (Counselor)

Finally, in the Clinic, professional practice included professionals turning to each other for peer support, in addition to providing treatment to clients. Clients' situations were complex and challenging, and working with clients was emotionally difficult and at times demoralizing. As part of self-care, professionals would seek each other out for peer support, looking to each other for

external validation of the treatments they were providing to clients. These quick, frequent peer-support interactions were facilitated by the open-door policy. Within the clinic, I observed professionals interacting outside of the clinic as well, for example entering the facility together, riding the elevator together, and having breaks together. Peer support and peer interactions were a normal part of clinic practice and also helped to trivialized task boundaries.

> It is amazing how [other professionals] will sit there and be like 'oh my goodness, I'm so overwhelmed I have to do this, this, this' … And then you say, 'Can I talk to you for a second?' and they say, 'Oh for sure'. They always do (Social Worker)

All of these disrupting actions - interacting and practicing across task boundaries, cross training, engaging in peer support – were disrupting to traditional practice because they required professionals to pay attention to and explore problems and solutions outside of traditional task boundaries. Professionals with addiction expertise had to pay attention to and explore mental health problems and solutions, and vice versa. In addition, professionals were paying attention to each other's problems and not just clients' problems. Task boundaries, which previously would have justified professions only focusing on clients' problems within jurisdictions were trivialized as professionals became increasingly comfortable exploring clients' mental health and addiction problems and exploring their own problems with others in the clinic.

Recognizing expertise and not hierarchy in the division of labor

Traditionally, professional practice is ordered through hierarchy, with medical professionals at the apex and other professionals located below. In the hierarchy, professionals follow particular interaction rules, for example, psychiatrists delegate work to other professionals and have the greatest independence in practice. This division of labor respects traditional values of professional practice - status, task boundaries, and independent practice. Hierarchy is, however, only one way to divide labor between different professions. In the clinic, disrupting actions had been taken that

ordered the division of labor around expertise instead of hierarchy.

Psychiatry and clinic practice. Managers had negotiated with psychiatrists how to incorporate psychiatry consultation into clinic practice in a way that supported integrated, collaborative practice. The psychiatrists acted as specialized consultants but were otherwise divorced from clinic practice. Psychiatrists attended the clinic three half days each week, and counsellors, social workers, psychologists, and nurses scheduled consultations for clients they felt would benefit from a psychiatry consultation. Prior to the consultation, clinic professionals would provide an update to the psychiatrist, identifying the issues they felt he or she should address. Clinic professionals attended and participated in the consultations and interacted informally with psychiatrists post consultation. Finally, although psychiatrists made treatment recommendations the clinic professionals were ultimately responsible for determining with the client which treatments they would pursue.

> We [managers and psychiatrists] have had conversations … a number of sessions together, 'Well, what do you want from me? … I work here part time as a consultant psychiatrist to the team. (Psychiatrist)

> [In the clinic we are] able to talk to [the psychiatrist] about clients … [If clients] also have addiction issues you can help the doctor decide what kind of medications and what kind of treatment they will receive … so that they are not as addictive. (Social Worker)

> I sit in the [psychiatry] sessions … [we] can talk over the treatment plan [they will] say, 'This is how they presented, what do you think?' (Psychologist)

> I was in a [psych consultation]. The psychiatrist said you know I'm thinking it would be good for [the client] to do this, and said it to the client. And of course the client's like, 'Yeah', to the doctor, 'Yeah right. Sure.' But the minute that we sat down again it was like, 'No. I don't want to do that'. And I said to the psychiatrist after, 'We talked about different treatment options and definitely we explored, but [no, the client does not what to do what you recommended]. (Social Worker)

Recognizing specialized expertise. Expertise also organized labor between the staff professionals. Professionals turned willingly to each other to gather information and to explore clients' problems. When other professionals jumped into case conference presentations with ideas and insights,

professionals responded without affront, recognizing that expertise was being providing in a reflexive, uninhibited way because of how different professionals understood clients' problems. In the clinic, recognition of each professionals' expertise also underpinned each professionals' authority to determine which recommendations they would implement in treatment.

> When the case conference starts and someone is presenting about a client sometimes we are impatient we will just start asking questions like 'when was the last time they assaulted their partner?' … we will ask for the details and sometime the person will have the answer sometimes they will be like, 'Well I didn't have a chance to ask that or I didn't think about asking that'. (Counsellor)
>
> [In case conference] people are quick to say, 'Oh what about this program?', or, 'Did you talk to them about [drinking, relationships, work, finances, particular treatment programs or approaches …]?' … They are really open with resources and what they know. (Nurse)

Actions taken to recognize expertise over hierarchy were disrupting to traditional practice. The limited role for psychiatry, and the ways that professionals and psychiatrists interacted within the clinic were counter to the hierarchical interactions that typically organize multi-profession labor. Staff professionals – psychologists, nurses, counsellors, and social works – held more control in the clinic than did psychiatrists, and psychiatrists readily handed over responsibility for clients to the staff professionals. Psychiatrists recognized the expertise of the other professionals, knowing that they would implement treatments in line with clients' wishes. In addition, actions that respected expertise rather than boundaries were also disrupting to traditional practice. In Clinic A, professionals recognized that other members held specialized expert knowledge that could provide insight to clients' problems and resources for treatment. As professionals become used to acting in ways that respect expertise over task boundaries this helped with ongoing disrupting of traditional practice. Incrementally boundaries become less important in Clinic practice, disrupting rather naturally the traditional organizational of professional labor.

Absolving the expectation that professionals are problem solvers

The different knowledge of clients and professionals contributes to a boundary above which

professionals are problem solvers and below which clients are treatment receivers. Practice in the clinic repositioned the knowledge of professionals and clients, placing clients' knowledge of self at least on part with professionals' expertise. In the clinic, client goals drove treatment and managers pushed professionals to recognize clients' strengths and bring these into client-directed treatment plans. The strength based presentation form (SBPF) – adapted as a tool in case conference - minimized the problem oriented approach to clients (i.e. symptoms, problem diagnosis, and treatment plan) and pushed professionals to seriously pay attention to clients' goals, and strengths. It also required professionals to describe a personal connection with clients, shifting the client/professional relationship away from a problem-solver/solution-receiver relationship. Professionals found it challenging to present in this way. Some came to case conference with pre-scripted points that outlined a connection, and others tried to skip the question altogether. Managers did allow professionals to defer describing a connection, but required them to do so prior to signing off the form. When professionals were really stuck, others would offer possible connections.

> Before in case conference we jumped into the person's history the problems … we come up with the treatment plan. A person outside of the field would listen to a lot of heavy, heavy stuff, about abuses and substance use … The structured set of questions [in the SBPF] puts the focus on the person's strengths their goals, things that they are good at, our connection with the person … (Counsellor)

> If people [professionals] are really struggling with the strengths piece at the beginning [of case presentation] we will move on we will talk about their story and then collaboratively we will come together and be like, well you mentioned this (Social Worker)

> [The Clinic practice] allows you to go [forward with] whatever the client gives you. I never used to look at concurrent or addiction that way before … [Here I work on what the client wants to work on]. (Nurse)

In the clinic, clients' knowledge and strengths were elevated and professionals had to position themselves differently with respect to clients and had to use their expertise differently. In this, professionals were absolved from having to solve clients' problems. Instead, clinic professionals aimed to help clients achieve better quality of life, however this was defined by clients. Managers

reinforced to professionals that clinic practice was not all about problem solving, but included connecting and interacting with clients on a human level.

> The role of [professionals in the clinic] is not to fix or prescribe or whatever. … [Clients] need to be educated and given the resources to … move forward. If they lapse, or if they go off their meds, they need to feel comfortable in going to a safe place where they trust [professionals] to help them get back on track. (Director, Alberta Health Services)

> Working with a client and their treatment plan it's an on-going live document … it's forever changing [depending on what the client wants]. (Counsellor)

> [I know treatment is working when clients] report that things are better for them … if they say that things are better, then maybe something is working and we will continue on that … [not actually solving a problem]. (Nurse)

Activities that reposition client knowledge vis-à-vis professional knowledge and that absolve professionals need to be problem-solvers is disrupting to traditional professional practice. In the clinic, professionals acted more like solution seekers, finding tools from different knowledge jurisdictions and offering these tools to clients so that clients could work towards their own goals. Even in the earliest contact with clients, professionals enacted a solution seeker role, asking clients for feedback on what they wanted to work on in treatment. These kinds of actions disrupt traditional values of professional practice, in particular values that uphold professionals as expert problem solvers and professionals are the definers of what problem solving entails.

In summary, professional practice was disrupted in the clinic because of boundary work, or activities that were disrupting to the hierarchy and task boundaries that traditionally shape professional practice. In the clinic, activities were trivializing to task boundaries, minimizing their importance in the day-to-day interactions between professionals and clients and between professionals themselves. Actions and interactions in the clinic also recognized expertise over hierarchy, disrupting traditional interactions between different professions and supporting the enactment of more collaborative interactions. Finally, actions that elevated clients' goals and

strengths by place clients' knowledge alongside professionals' knowledge disrupted the boundary that positioned professionals as problems solvers and clients as solution receivers.

Summary

In the part 2 study, I explored the question, *how do actors disrupt professional practice?* My findings show that professional practice was disrupted through three kinds of disrupting work: configuring work, adapting work, and boundary work. *Configuring work* includes activities that purposefully shape space, staffing models, and relationships to support practice disruption and movement towards integrated and collaborative practice. *Adapting work* includes activities that re-design specific activities of practice and tools of practice to support the desired practice. *Boundary work* includes activities that trivialize (in a positive way) task boundaries, that recognize expertise and not hierarchies in the division of professional labor, and that absolves the expectation that professionals are problem solvers. These forms of work are disrupting to the traditional values of professional practice – independence and autonomy, task boundaries, respecting hierarchy, and expert problem solving. These forms of institutional work are also connected. The space configured for the clinic resulted in space appropriate for case conferencing and joint assessments. The engineered staffing model pulled together a set of professionals with openness to integrated and collaborative work. Building on these, adapting work and the re-design of particular activities and tools slowly disrupted traditional practice, incrementally shifting it towards something different and reinforcing shifts over time. Finally, boundary work arose from the activities of professionals and managers as they explored practice shaped by configuring work and by adapting work. These findings are illustrated in *Figure 4: Work involved in disrupting professional practice.*

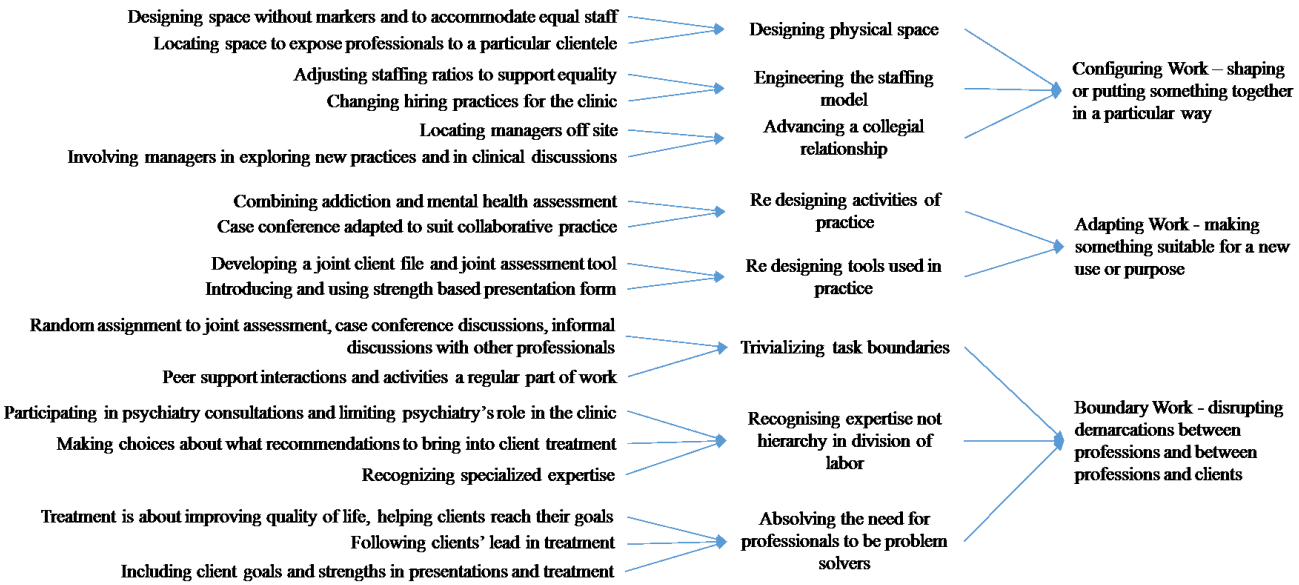

Figure 4: Work involved in disrupting professional practice.

CHAPTER 5: DISCUSSION

Given the central assumption in neo-institutional theory that the behavior, and action, of actors is prescribed by institutions (e.g. Meyer and Rowan, 1977; DiMaggio and Powell, 1983) empirical studies have long ignored action. However today, there is renewed appreciation for the link between action and institutional life. Under the banner of institutional work, Lawrence and Suddaby (2006) sketched out an early understanding of action drawing from theoretical statements that featured action prominently (e.g. DiMaggio, 1988; Oliver, 1991) and empirical studies examined action in relation to institutional dynamics. Today, our understanding of institutional work has grown, in particular in relation to maintaining work and creating work. However, as lamented by Lawrence and Suddaby (2006), attention to and understanding of disrupting work continues to be sparse. This is an important gap. Actors involved in disrupting actions are, arguably, actors who have been able to some way step away from institutional constraints but in a subtle, less heroic way than traditionally depicted in institutional literature (e.g. Hwang and Colyvas, 2011; Suddaby, 2010). My objective in this dissertation research was to explore disrupting action in a mature field with incumbent professions. In my examination of the Alberta addictions treatment field, undertaken through a case study in two parts, I explored disrupting actions, allowing me to extend and augment the understanding of disrupting work in the following ways.

First, my analysis highlights the subtle effects of disrupting action in a mature field with incumbent professions. I conducted my study in a field where the field's issue sat within the jurisdictions of particular professions, and where institutionalized professionalism and sociological settlements shaped the arrangements and practices of field incumbents. The institutional and sociological character of the field was such that disrupting aimed at the professions themselves would be expected to be rather ineffective (e.g. Currie et al., 2012; Kellogg, 2012; Micelotta and

Washington, 2013). Yet, in the field, actors were purposefully and intentionally engaging in disrupting actions that were having an effect. I believe that this was so because disrupting actions did not fundamentally or directly challenge incumbent professions' institutionally and sociologically organized arrangements and practices. While extant research tells us that disrupting mature fields is exceedingly difficult, in particular when field membership includes professions (e.g. Micelotta and Washington, 2013), my analysis suggests that actors can engage in disrupting action in these fields, and that incumbents also can partake in disrupting.

My analysis highlights some new forms of disrupting action and draws out some nuances of previously identified forms of disrupting action (e.g. boundary work). The disrupting actions uncovered through my analysis, at both the field level and the practice level, showed that actors avoided engaging in hostile disrupting actions, i.e. they did not attempt to disrupt rewards and sanctions or disassociate and undermine moral foundations and assumptions and beliefs (Lawrence and Suddaby, 2006). Instead, complexifying work and temporal work (at the field level) and configuring and boundary work (at the level of practice) included disrupting actions that did not threaten the essential nature of incumbents' arrangements and practices. Disruptors were very aware that having incumbent professions on side was critical. Hence, these actors recognized the expertise of incumbent professions and with them explored how traditional expertise could be used within a more complex understanding of the field's issue and how traditional arrangements and practices could be disrupted in the pursuit of an alternate future. Ultimately, action that engaged professionals as disruptors allowed field incumbents to be drawn into disrupting action without experiencing this as a direct challenge. Rather than theorizing disrupting action in a mature field as something that happens to incumbent professions and something that challenges fundamental elements of their organized life, my analysis suggest that disrupting work can be creative and inclusionary of field

incumbents themselves.

Finally, my findings shows how temporal disrupting work, of the form of small here-and-now projects and small future projects (field level) and small ongoing adaptations to activities of practice (practice level), characterizes disrupting in a mature field with incumbent professions. My findings suggests that temporally restrained disrupting work contains disrupting ripples in space and time connects ripples through time, and can be effective in disrupting a mature field with incumbent professions. This speaks to the potential for disrupting to represent a distinct and extended phase of the institutional lifecycle in mature fields with incumbent professions. Rather than theorizing disrupting action as something that happens and that has an immediate effect, my findings speaks to the on-going character of disrupting work. It also points to the collectiveness of disrupting work because disrupting requires the involvement of multiple actors who pull experiences and knowledge together to plan and implement disrupting in the present and in the future.

The disrupting actions uncovered through my study of a mature field with incumbent professions highlight the effort and intentionality that underpin disrupting work, showing that this work is very much purposeful (e.g. Lawrence and Suddaby, 2006). Some disrupting action can be classified as strategic, implying the identification of a long term objective and the means through which to achieve this. However, my findings show that disrupting work in a field with incumbent professions can also be of a fluid and creative nature. Ripples set in motion by specific disrupting actions can interrupt traditional arrangements and practices, and can connect (hopefully) over time so that ripples spread more broadly through the field. The nature of ripples, however, is that they are not linear. One ripple may cancel another, may magnify another, and may join with another sending both in different directions. Actors engaging in disrupting action have to be creative as they work within these ripples.

A Focus on Disrupting Work

The first contribution of my research is a focused examination of disrupting work. To *disrupt* means to 'interrupt (an event, activity, or process) by causing a disturbance or problem' (Oxford, 2015). In empirical studies of institutional work, explicit attention to disrupting has been scarce. Although field studies point to the importance of disrupting work (e.g. Lawrence and Suddaby, 2006; Maguire et al., 2004; Suddaby and Greenwood, 2005; Zietsma and Lawrence, 2010), detailed descriptions of how disrupting work actually interrupts institutionalized field arrangements and practices remains in infancy. In addition, the relatively thin understanding we do have implies that known forms of disrupting work are useful at disrupting all fields regardless of the character of these fields. My study starts to rectify this, explore disrupting work in a particular kind of field, and in a field where extant studies suggest that disrupting will be relatively ineffective.

The field I studied is a mature field with incumbent professions, and is a field formed around an issue of social importance. Within this field, stability has been maintained because institutionalized understandings and values underpin professional practice, and institutionalized sociological structures order professional labor. The few available studies of institutional work in similar fields suggest that field incumbents will neutralize the disrupting actions of other actors (e.g. Micelotta and Washington, 2013). My studies, however, show that disrupting work in mature fields with incumbent professions can interrupt extant arrangements and practices. At the field level, my analysis shows the importance of configuring work, boundary work, and temporal work, and at the practice level, my analysis identifies configuring work, adapting work, and boundary work.

My study shows the importance of exploring disrupting work in particular kinds of fields (a mature field with incumbent professions) highlighting the nature of particular forms of work when these are undertaken in different fields. My study of disrupting work in a particular kind of field

draws attention to limits of parsimonious models that necessarily suppresses meaningful variation within abstract categories. For example, extant literature describes boundary work in a mature field as work that redefines the field's boundary so that a new boundary develops that includes stakeholders from outside of the field who were critical of the field (e.g. Zietsma and Lawrence, 2010). In contrast, in my study of a mature field with incumbent professions, field level boundary work increases interactions between previously unconnected actors who, prior, had paid very little attention to the field. In addition, at the micro level of practice, my study uncovers another form of boundary work that involves actions that disrupt the demarcations between professionals and between professionals and clients.

Disrupting work at different levels, and connecting levels

The second contribution of my research is to explore disrupting work at different levels in a mature field with incumbent professions – the field level and the practice level – and to connect disrupting action between these levels.

Disrupting work at the field level

My findings suggests that actors can engage in disrupting action in a mature field with incumbent professions without directly challenging incumbent professions and can even draw incumbents into disrupting work as active participants. In particular, disrupting work takes a non-confrontational form specifically avoiding dissociating rewards from existing practice, rules, or technologies and disrupting the normative underpinnings of professions' practice (Lawrence and Suddaby, 2006). For example, complexifying work that bundles problems and disrupts simple issue framings draws incumbent professions into new spaces. When combined with boundary work, it encourages incumbents to engage in collegial explorations to examine what complexity means for the field. Complexifying work that avoids jurisdictional challenges to

incumbent professions' expertise (e.g. Abbot, 1988) is similarly collegial not confrontational. Through complexifying work, each professions' problem of concern and particular expertise is recognized and is located within a more complex issue understanding rather than being challenged, reducing the chance that professions will engage in neutralizing identity work (e.g. Lok, 2010) or boundary bolstering work (e.g. Zietsma and Lawrence, 2010).

Boundary work also takes a collegial collaborative form rather than a confrontational form as depicted in other studies (e.g. Zietsma and Lawrence, 2010). In mature fields with incumbent professions, field level boundary work does not attempt to redraw boundaries around incumbent professions (Currie et al., 2012) nor does it try to remove boundaries that sustain professions' authority (Micelotta and Washington, 2013). Instead, boundary work is intentionally and purposefully exploratory and engaging, pulling together previously unconnected actors (incumbent professions included) in neutral spaces and providing opportunities for these actors to explore connections. Boundary work aimed shaping an inclusionary boundary around a field's issue likewise involves actions that encourage professionals to see how clients would benefit from other expertise, rather than criticizing incumbent professions for being exclusionary. Like with complexifying work, collegial boundary work achieves disrupting because it avoids creating situations where incumbent professions respond with maintaining action.

My analysis shows that temporal disrupting work also is of a particular form and includes particular types of action. Temporal disrupting work includes the implementation of small local projects and (re)education projects that aim to disrupt field incumbents, but in local spaces where disrupting ripples can be contained and minimized. It also includes future planning projects and the deferral of projects that, if undertaken in the present time, would create large disrupting shocks (tsunamis rather than ripples) in the field. Temporal disrupting work is not dramatic. It takes place

over time and initiates, but minimizes, ripples in the field. In a mature field, temporal disrupting work normalizes disrupting in a way that is non-threatening to incumbents. While other studies identify the importance of temporal institutional work in mature fields (e.g. Jones and Massa, 2013), my study shows how temporal disrupting action minimizes and contains ripples in the present and ensures that ripples continue to disrupt the field over time.

My field level analysis draws attention to the process of disrupting a mature field with incumbent professions. Disrupting a mature field starts with complexifying the field's issue by bundling it with other problems and by disrupting simple framings. This sets the stage for boundary work where incumbent professions and other actors begin to interact and explore the implications of a complex, wicked field issue. The complexified issue is important for boundary work that increases interactions between previously unconnected actors because it draws actors' attention to the connections between problems and does not challenge traditional problem understandings, per se. This creates an environment where incumbents and other actors can concentrate on exploring the implications of connections rather than defending jurisdictions. As implications are identified, actors engage in temporal work, designing small local projects for the present and future. While this description of the connections between types of disruption work may appear linear it is a recursive process, as depicted in *Figure 5: Disrupting work in a mature field with incumbent professions*.

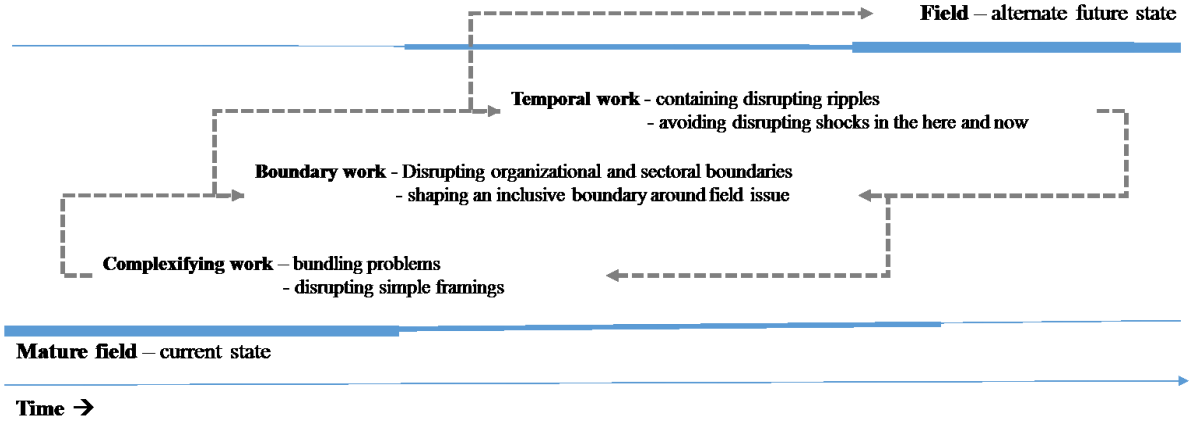

Figure 5: Disrupting work in a mature field with incumbent professions.

Complexifying work supports boundary work, and boundary work introduces new complexities into the understanding of a field issue, which then require additional complexifying work. Likewise, boundary work may identify opportunities for present day or future small disrupting projects (temporal work), which may require targeted boundary disrupting work in order for these projects to come to fruition. Finally, temporal work may identify additional opportunities for boundary and complexifying work.

Disrupting work at the level of professional practice

In contemporary institutional scholarship, empirical studies have provided an explanation of the action involved in replacing old practice with new (e.g. Jones and Massa, 2013), however we lack an understanding of how institutionalized professional practice might be disrupted and developed into something different. This question is of particular importance when actors see value in traditional practice, but also see that value can be enhanced by disrupting the old. My micro level practice study develops an action centric, process oriented explanation of disrupting professional practice, summarized in *Figure 6: Disrupting work involved in disrupting professional practice.*

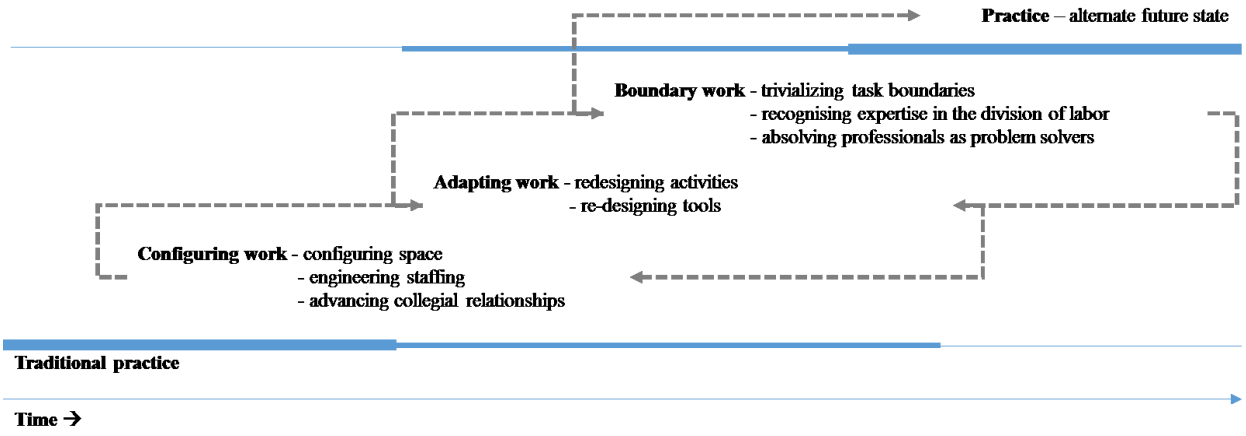

Figure 6: Disrupting work involved in disrupting professional practice.

Action implicated in disrupting professional practice has a particular nature. Similar to field level disrupting work, practice level disrupting work is non-confrontational and involves professionals as disruptors. It also avoids the heavy-handed disrupting actions described by Lawrence and Suddaby (2006). My analysis shows configuring work as instrumental in developing safe collegial environments and relationships – spaces - in which other practice disrupting activities take place. Once space has been configured, adapting work targets disrupting at only the smallest elements of professional practice – individual activities of practice and the tools used in these. Finally, and only after a minimum of configuring and adapting work has been accomplished, do professionals' own day-to-day actions in configured space and adapted practice contribute to boundary work. My analysis shows that once professionals are enacting practice that has been disrupted through configuring and adapting work, professionals' own actions further contribute to disrupting the traditional values of professional practice.

The strength of the institutions and sociological structures associated with professionalism and professional work tend to be regarded as all constraining where professionals are involved, making it difficult to explain the disrupting of professional practice except by natural variation or improvisation (e.g. Lounsbury and Crumley, 2007; Smets et al., 2012). This idea is further reinforced by the substantial literature that shows, in practice, how challenging it is for professionals themselves to disrupt practice even when conditions are put in place that should encourage disrupting (e.g. Brown et al., 2011; Hall, 2005). However, my findings shows that action centric models of practice disrupting can be put in place. My analysis of action involved in disrupting professional practice incorporates agency and shows that disrupting professional practice involves intentional, purposeful actions, engaged in at particular times and with skill, patience, and persistence. In addition, my findings shows that professionals themselves can be very much

involved in disrupting their own practice, implying that the institutions of professionalism are not always as constraining as previously thought (e.g. Hwang and Colyvas, 2011)

In contrast to practitioner models that highlight the futility of disrupting professional practice and the institutional models that take a 'wait and see' approach to new professional practice, the model of disrupting professional practice developed here suggests that there are ways to directed and purposeful ways to disrupt professional practice. At the practice level, configuring work and adapting work are helpful in moving disrupting work forward in ways that are not overtly challenge to professionals. As configuring and adapting work interrupts traditional practice, professionals own actions start to contribute to boundary work that further disrupts practice. The model of disrupting professional practice proposed here may help avoid the neutralizing countertactics observed in other settings (e.g. Kellogg, 2012).

My analysis suggests that disrupting work at the practice level is recursive and additive, over time reinforcing disruptions made prior while continuing to introduce new disruptions. Configuring work builds the conditions to support adapting work and encourages boundary work by professionals. As boundaries are disrupted, additional configuring and adapting work are engaged in, triggering ongoing boundary work. Each kind of disrupting work is ongoing once started, however loop-backs to different kinds of disrupting work can occur at any time. This speaks to the agency and intentional action of actors pursuing practice disrupting. Actors have to be aware and reflective of the overall process of disrupting and where disrupting needs to be directed of redirected. This presents a different picture of practice change than that which is presented in actorless models that speak nothing to the purposeful, ongoing involvement of actors and action and how this connects to the creating (e.g. Lounsbury and Crumley, 2007; Smets et al., 2012) or disrupting of professional practice. It also speaks to how actors become capable of engaging in

actions that are not constrained by institutional templates (Powell and Colyvas, 2008; Hwang and Colyvas, 2011).

Connecting disrupting action and work between levels

Lawrence and Suddaby's (2006) original typology of disrupting work focus on work at single levels, and for the most part research conducted since continues this tradition. While other studies have shown how the regular enactment of routine practice maintains broader social institutions (e.g. Dacin et al., 2010) and how work that changes identity and role boundaries can result in change at the macro level (Leung et al., 2014), to date no studies explore connections between practice and field disrupting. My study is the first attempt to explore disrupting work at multiple level and to examine the connections between levels. In mature fields with incumbent professions, the combination of field level and practice level disrupting work is important. Field level disrupting work creates the environmental conditions that provide collective support for small, local disrupting projects. Practice level disrupting work is necessary to ensure that local disrupting ripples are initiated. Field level disrupting work develops the conditions that allow bottom up disrupting to take place, practice level disrupting work ensures that practice is actually disrupted.

While disrupting work undertaken in local settings disrupts practice in these settings, it minimizing disrupting outside of the local site. This is where temporal work undertaken at the field level connects back to practice level disrupting work. Temporal work includes the design of future disrupting projects. Some of these projects can be designed to propagate particular disrupted practice through the field. Temporal disrupting work can also be used to contain local disrupted practices that show unintended and undesirable effects. Importantly, for each future small disrupting project, practice disrupting work will be necessary to ensure disrupting in local settings. When disrupting a mature field with incumbent professions, action never takes a back seat; it remains in

the foreground, as summarized in *Figure 7: Connecting Field and Practice Disrupting Work.*

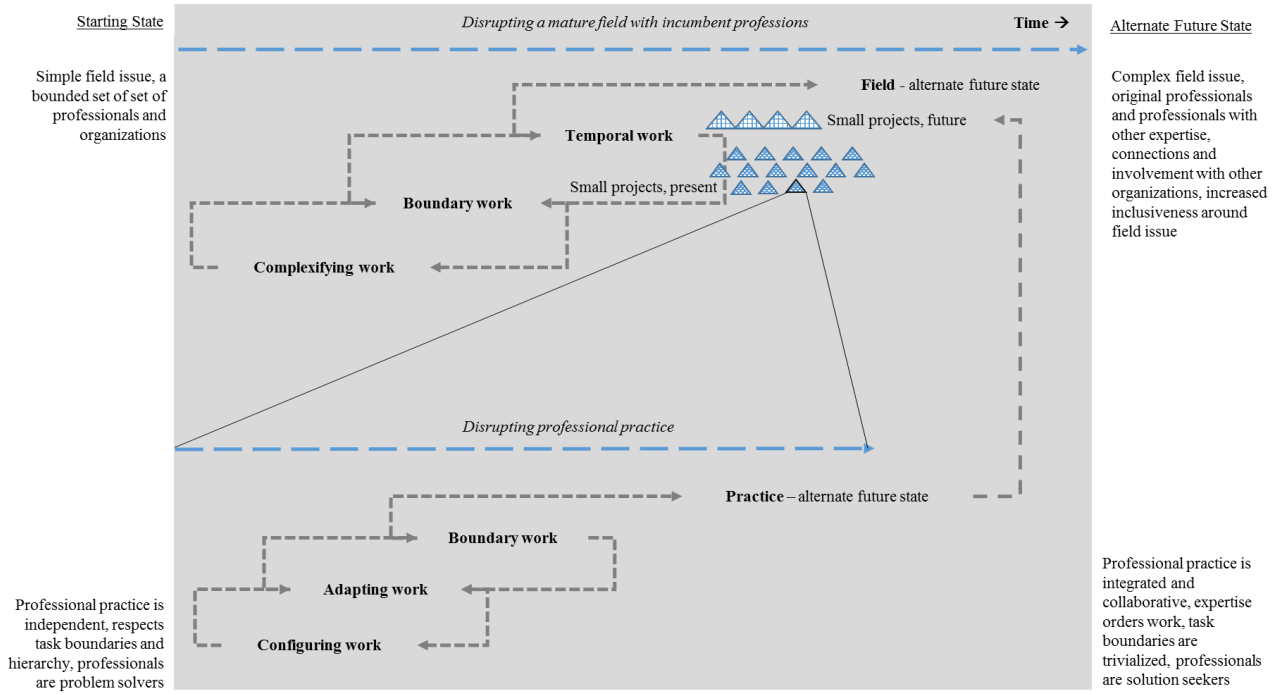

Figure 7: Connecting field and practice disrupting work.

The multi-level disrupting model developed from my research presents an agentic approach to disrupting a mature field with incumbent professions. Traditional models of change in mature fields with professions do not include actors or action (e.g. Kirkpatrick et al., 2005; Scott et al, 2000). More recent models suggesting that field conditions, specifically institutional complexity, creates conditions in which new practices might be created and spread (e.g. Greenwood et al., 2011), or that new practices spontaneous appear through random variation and then subsequently diffuse through these mature fields (e.g. Lounsbury and Crumley, 2007). My model, in contrast, draws attention to purposeful and intentional disrupting actions at the field level and the practice level and shows how these are connected.

Intent and Effort in Disrupting Work

The third contribution of my research is to highlight the intentionality and effort involved in

disrupting work. The few nods to disrupting work in mature fields suggest that disrupting work is undertaken by actors who feel strongly that field incumbents' interests are being realized through existing institutional arrangements and that other's interests are being ignored or suppressed (e.g. Bertels et al., 2014; Zietsma and Lawrence, 2010). This includes, for example, the disrupting actions undertaken by state actors who feel that professions' interests dominate in mature fields (e.g. Micelotta and Washington, 2013) and the disrupting actions of social movements and challengers external to fields (e.g. Bertels et al., 2014; Zietsma and Lawrence, 2010). The intent or motive underpinning disrupting action thus is associated with a desire to invert inequality by 'attacking' field incumbents.

My study, however, suggests that actors engaged in disrupting work are not motivated to suppress incumbents' interests, but instead are motivated to engage in disrupting work because they envision an alternate future in which incumbents' and other's interests are realized together. Disrupting work in a mature field with incumbent professions is not about suppressing and abandoning traditional structures and practices that sustain particular interests. Instead it is about finding ways to interrupt these so that incumbents and other actors can together enact a different future. This envisioning work is different from that described by Jones and Massa (2013) who identify visionary prophets as actors who *offer* alternate futures. Disrupting actors do not offer the alternate future, instead they purposefully and with intention engage in disrupting work that creates the conditions in which field incumbents willingly collaborate with other interested social actors in designing this alternative future in real time.

At the level of practice, the intent behind disrupting action is also not to challenge or disrupt professional practice, per se. At the level of practice, disruptors acknowledged the value of traditional professional practice and were clear that disrupting practice – making it more integrated

and collaborative – was about designing practice that would better serve clients and was not being punitive to the professions involved. At the practice level, an alternative future also motived disrupting work. Indeed, even when professionals and managers were engaged in long-term purposeful action that was exploratory and fuzzy the vision of an alternate future where practice addressed the whole client was at the fore.

The model of disrupting a mature field with incumbent professions developed through my research is particularly relevant for actors who want to disrupt a mature field but who want to involve incumbent professions, for example, when actors envision an alternate future in which wicked problems are resolved. Contemporary literature suggests that actors are starting to understand and explore the inherent wickedness of mature fields' issues and the implications of this for field arrangements and practices (e.g. Ferlie et al., 2013; Head, 2008; Rayner, 2006). However, disrupting arrangements (Ferlie et al., 2013), stakeholder interactions (e.g. Rayner, 2006), and professional practice (e.g. Conklin, 2006) will require purposeful and intentional disrupting, especially if there is a desire to avoided unintended and unforeseen consequences in the fields. My findings and the models explicated from these provide both theoretical and practical insights into disrupting mature fields with incumbent professions.

Collectivity and Disrupting Work

The fourth contribution of this research is to draw attention to the collectivity of disrupting work. Similar to other studies of institutional work, my study shows how institutional work is collective at the field level (e.g. Bertels, et al., 2014; Jones and Massa, 2013) and at the practice level (e.g. Lok and De Jordy, 2012). Disrupting work involves many different actors in fields, incumbent and new. It also involves actors at different levels – policy makers, professionals, top and middle managers in organizations. Collective work is undertaken by groups of actors,

sometimes together at one time (e.g. collaboratively exploring what complexity means for the field), other times separated temporally (e.g. senior managers do configuring work that supports ongoing adapting and boundary work at the practice level). Collective disrupting work is more than simply collaborating – working jointly on an activity, especially to produce or create something. Collective disrupting work sets the conditions that support collaboration, and in particular sets the conditions that encourage the constructive participation of powerful field incumbents. In my model of collective disrupting, akin to other change models that put collective effort centrally (e.g. Hargrave and van de Ven, 2006), the collective effort of actors at different levels and across levels is implicated in the disrupting of traditional institutions in mature fields.

My study also highlights the involvement of organizational actors in this collective disrupting work. However, unlike other studies that depict managers as the actors that do institutional work (e.g. Gawer and Phillips, 2013), my study suggests that managers do this work together with professionals and with other field incumbents.

Field Issues, Disrupting Work and Institutional Dynamics

The fifth contribution of this research is to locate the impetus for collective disrupting action in the changing understanding of mature fields' issues. Hoffman (1999) originally pointed to the important of issues in the formation of institutional fields. According to him, fields matured as actors came to understand an issue collectively and claimed an interest in the issue and relative to one another. As understandings and interactions mature so did the field. Since Hoffman's (1999) paper, issues have been used to identify fields (e.g. Bertels et al., 2014); however, scholars have not really extended the implications of issues for fields. My analysis shows, in line with Hoffman (1999), that a mature field's issue is understood in a particular way and that particular field actors' arrangements and practices are connected to that issue understanding. My analysis also shows that

actors can complexify an issue or expose its inherent wickedness through purposefully bundling the issue with other important social issues and carefully and intentionally creating metaphors that disrupt traditional conversations. Importantly, through action actors are not making an issue wicked, they are making visible the wickedness that has always been present.

As incumbent field actors and other actors start to explore issue wickedness, they start to envision an alternate future state where traditional arrangements and practices are interrupted and built into something different. While actors believe that disrupting needs to be accomplished in order for the field to reach its alternate future state, there is no particular timeframe within which their disrupting action takes place (e.g. Zietsma and Lawrence, 2010). My research suggests new temporal imagery for disrupting work. In particular, my study shows that actors involved in disrupting work do so not within distinct, bounded periods-of-times but over extended periods-of-time. Similar to Jones and Massa (2013) who showed that new practice consecration in a mature field is a multi-generational endeavor, disrupting work in a mature field with incumbent professions occurs over an indeterminate length-of-time. Indeed, because some activities of disrupting work are specifically oriented towards the pursuit of an alternate future, disrupting becomes a phase with a rather 'fuzzy' finish line. Disrupting thus represents a distinct and extended phase of mature fields' institutional lifecycle.

Designing Empirical Studies to Examine Disrupting Work

The sixth, and final, contribution of my dissertation research is to identify the importance of attending to disrupting work as it happens. The institutional tradition has been to conduct retrospective field-level empirical studies. These studies tend to focus on change and enclose disrupting work as a distinct short-lived phase (e.g. Zietsma and Lawrence, 2010), or use acute instances of hostile disrupting action to focus on field incumbents' maintenance work (e.g. Currie et

al., 2012). In contrast, and in following Lawrence and Suddaby's (2006) invitation to explore institutional work in all its forms and in the absence of known effects, my study allowed me to focus specifically on actors' disrupting actions.

In mature fields, disrupting work is not an acute event but rather a chronic state of affairs. This elevates the need to understand disrupting work for its own sake and not in connection to rather dramatic effects (Lawrence and Suddaby, 2006). My research suggests that scholars interested in disrupting work should not limit research to settings where institutional effects are known, but should explore fields where disrupting is taking place. This will require identifying fields under disruption and the actors engaged in disrupting. It will also require identifying small moments and more subtle interruptions and disrupting events and changes that will provide evidence that disrupting action is being undertaken and is having an effect. This approach is riskier than studying fields where effects of successful disrupting work are known, however it is more likely to uncover the varied sorts of disrupting action that actors engage in. It is also an approach that should provide opportunities to uncover how actors overcome institutional constraints and become capable and skillful of action unconstrained (or less constrained) by existing institutional models (Hwang and Colvas, 2011; Powell and Colyvas, 2008; Suddaby, 2010).

Summary

In summary, my study is the first empirical study, to my knowledge, that focuses explicitly on disrupting work. The study was designed to identify disrupting work in a particular type of field, a mature field with incumbent professions which prior research has shown is particularly difficult to disrupt. My analysis uncovered three kinds of disrupting work at the field level and three at the practice level, and identified connections between levels.

In this chapter, I drew attention to how intentional and purposeful disrupting work is, and to

its collective, collegial, and non-confrontational nature, in contrast other research that focuses on dramatic hostile disrupting actions of particular actors. The discussion also highlights the action involved in disrupting arrangements and practices in a mature field with incumbent professions, in contrast to other models that position this as an actorless phenomenon. My discussion shows that while disrupting work pursues an alternate future, this alternate future is not one in which incumbents' interests are necessarily suppressed, allowing others' interests to be realized. Finally, the discussion draws attention to the qualitatively different nature of disrupting work in a mature field with incumbent professions in comparison to disrupting work in other fields.

CHAPTER 6: CONCLUSIONS

Traditional institutional statements depicted actors' action as guided by institutions even though early statements implicated action in institutional life (e.g. DiMaggio, 1998). In contemporary institutional studies, action, however, is starting to emerge as a central construct, elevated in importance by growing attention to institutional work (Lawrence and Suddaby, 2006; Lawrence et al., 2009, 2011). In following with the traditional institutional focus on stability and change, empirical studies of institutional work have focused on exploring how action maintains institutions or creates them anew. These empirical investigations have foregrounded action implicated in these particular outcomes, implicitly back-grounding and suppressing disrupting action. As lamented by Lawrence and Suddaby (2006) disrupting remains overlooked. This is an important oversight in studies of action and institutions. Focusing on disrupting foregrounds not only the action implicated in disrupting extant institutions but also holds promise for developing a more nuanced understanding of when and how embedded actors become skilled at interrupting extant institutions, in the process overcoming the constraints that hold them to action that simply maintains. A focus on disrupting has the potential to uncover how embedded actors become 'liberated' from the institutions that constrain their action.

In my research, I endeavored to rectify inattention to disrupting, uncovering the different forms of action that contribute to disrupting a mature field with incumbent professions. In this research, I have shown that the arrangements and practices in mature fields with incumbent professions can be disrupted. Current statements about change in such fields imply that actors desiring new practices and arrangements must simply wait and hope that these emerge (and diffuse) through rather random practice variation. In contrast, my study shows that with intentional and purposeful action actors, including incumbent professions, can interrupt institutionalized practices

and arrangements and can shape an alternate future for mature fields. The model developed in this study provides insight into different kinds of disrupting action, how actions are connected across levels, the recursive nature of these connections, and the actors involved in these actions. This is one of the few models available today (see Zietsma and Lawrence, 2010) that places actors centrally in a model of disruption in a mature field. It is the only that places incumbent professions centrally in the disrupting model.

My research investigated a mature field with incumbent professions. In other research in similar fields (e.g. Currie et al., 2012; Micelotta and Washington, 2013) professions are shown to be neutralizers of other actors' disrupting actions, in the process maintaining the institutions in these fields. This, however, suggests that professions, as an institutionalized set of actors, are rather institutionally constrained and are beholden to reproduce and maintain extant institutional templates (e.g. Powell and Colyvas, 2008; Hwang and Colyvas, 2010). My research suggests otherwise, showing that the actions of incumbent professions and professionals' have a role in (re)problematizing mature field issues and interrupting their own long-standing arrangements and practices, even as their actions sometimes maintain certain elements of traditional practice. In addition, my research provides a counter perspective to the traditional statement that professions exist in systems that support institutionalized competition between professions and between professions and other actors (e.g. Abbott, 1988; Freidson, 2001). Indeed, the idea that heterogeneous groups of professions can work collaboratively and collegially with one another and with other social actors has yet to find a place in institutional studies and studies of the professions. This idea that competition is not inherent to professionalism and professional work is an important insight, as it suggests that the meaning of professionalism and professional work might be interrupted in different contexts (Suddaby, 2010). It also suggests that professionals are important,

possibly necessary actors, in collectives whose aim it is to disrupt long-standing institutions.

My dissertation research draws out the collective nature of disrupting work both at the field level and at the practice level. Collective action, in and of itself, is not a new insight in institutional studies (e.g. Hargrave and van de Ven, 2006). However, the insight offered through my research is that collective disrupting work can be collegial. Importantly, when incumbent professions are the target of disrupting work, collective action draws them into disrupting as involved participants. This kind of collective disrupting work is not political, as it does not focus on recombining inherited practices and institutions to address 'partisan interests' (Hargrave and van de Ven, 2006: 865). In my studies, disrupting action nods to professions' interests, but the assumption is that professions will set their partisan interests aside for an interest in the greater good.

Finally, a focus on disrupting action is very much in support of the premise that action underpins institutional life (e.g. Jepperson, 1991). It draws attention to the myriad of actions that have the potential to interrupt extant institutions, but also that might fail to disrupt these same institutions. Disrupting occurs in real time, but has long temporal implications and consequences, which cannot be foreseen when disrupting action is undertaken. Attention to disrupting work highlights the very real ways that action is connected to both the interrupting of extant institutions and to how these actions might fail.

The Alberta addictions treatment field was particularly well suited for exploring disrupting work because it was evident that both incumbent professions and other actors were partaking in action aimed at purposefully disrupting extant institutions. This speaks to the need for scholars interested in disrupting work to design empirical studies carefully so that the nuances of, and actors involved in, disrupting action have a chance of being observed. Although I am confident in the findings of this research, the generalizability of my findings to other settings will need to be

established through future research. Some of this research could be undertaken in the field of addiction treatment as the temporal nature of disrupting action means that it will remain visible for some time. Additionally, research could be undertaken in other fields where issues have been identified as wicked, such as public health or aging (e.g. Burns, Hyde, and Killett, 2013; Ferlie et al., 2013). Ongoing research in the healthcare could, for example, confirm the conditions in which disrupting work appears, and whether the kinds of disrupting work observed here are contingent on the professions involved. Future research could also explore disrupting work in fields not associated with healthcare, including public policy fields (Head and Alford, 2013) or natural resource fields where different economic and environmental understandings of natural resources are pushing actors to disrupt arrangements and practices (e.g. Brooks and Champ, 2006; Brown, 2009). In this research, it would be interesting to understand whether the same forms of disrupting work are at play or whether new ones arise given the professions, practices, and arrangements in place. Finally, it would be interesting to explore more specifically how and when professions and professionals are able to engage in agentic action aimed at disrupting their own institutionalized practices and arrangements of work. I believe that insights into these kinds of questions could significantly advance understanding of disrupting work and agency and action in institutionalized settings.

In closing, my research contributes to developing the emerging perspective of how action matters in institutional life, in particular the disrupting of institutional life. This research depicts the centrality of social actors' collective disrupting action to institutional life and institutional dynamics without diminishing or ignoring organizational institutionalisms' long history of explaining how the institutional environment matters.

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APPENDIX A: RECRUITMENT AND CONSENT FORMS

Part 1 Study – Field actor interviews

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Department of Strategic

Recruitment and Consent Form
Title of the study: The dynamics of interprofessional collaboration

Research Investigator:
Jo-Louise Huq, PhD Candidate
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Email: jhuq@ualberta.ca
Tel: 780-289-3510

Supervisor:
Dr. Patricia (Trish) Reay, Supervisor
Alberta School of Business
PhD Office, Business Building
3-23 Business Building
University of Alberta
Edmonton, AB, T6G 2R6
Email: trish.reay@business.ualberta.ca
Tel: 780-492-4246

Invitation to Participate: You are invited to participate in the above mentioned research study conducted by Jo-Louise Huq, supervised by Trish Reay, and funded by the Social Sciences and Humanities Research Council of Canada. You were selected as a potential participant because you are knowledgeable about the changing understanding of substance abuse and its potential impact on professional work, for example new work arrangements for professionals such as interprofessional collaborations.

Purpose of the Study: The purpose of the study is to examine the changing understanding of substance abuse and how this might impact professional work, for example encouraging the creation of interprofessional collaborations. Specifically, the study aims to investigate how governments, professional associations and educational institutions influence the practice of interprofessional collaboration. It also aims to understand the internal dynamics of interprofessional teams in terms of socialization of team members and leadership dynamics, in health care.

Participation: You are asked to participate in an interview that will last approximately one hour. Participation will consist of providing your views on the changing understanding of substance abuse and the impact of this on the organization and practice of professional work.

Risks: There are no foreseen risks associated with your participation in this study.

Benefits: Your participation in this study will contribute to the advancement of knowledge on the dynamics of interprofessional collaboration in health care settings.

Confidentiality and anonymity: The researchers will take their best efforts to ensure that any information that is collected from you, and that can be identified as having come from you will remain confidential. All information gathered will be used for the purpose of the research and confidentiality and anonymity will be protected to the best of the researchers' abilities. Only research team members will have access to interview transcripts. Since it is common for research based on interviews to report quotations from participants, if your quotations are used in written reports, your name and position title will be disguised. Quotations that would allow identification of the source will not be used in research reports and publications. You will be given the opportunity to review your interview transcript. Reviewing the transcript will entail providing the researcher with a mailing or email address. If you choose to receive the transcript by email, there is a risk of it being intercepted by someone in the organization or by a hacker, thus risking confidentiality.

Conservation of data: The data collected consisting of digital recordings and transcripts of interviews will be kept in a secure manner. Digital recordings will be stored on USB keys that will be kept in the researcher's office under lock. Interview transcripts will be saved on computers protected by password and used by the research team members only. The data will be stored for a period of 10 years and destroyed after that time.

Voluntary Participation: You are under no obligation to participate in this research. If you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be deleted.

If you have any questions about the study, you may contact Jo-Louise or Trish. Our contact information is written on page 1 of this document.

If you have any concerns about your treatment or rights as a research participant, you may contact the University of Alberta Research Ethics Office at 780-492-2615.

Acceptance: I, _____, agree to participate in the above research study conducted by Jo-Louise Huq, and supervised by Trish Reay, both of the University of Alberta School of Business.

There are two copies of the recruitment and consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Part 2 Study – Clinic interviews and observations

INFORMATION LETTER and CONSENT FORM
Study Title: Professional collaboration and institutional pluralism.

Research Investigator:
Jo-Louise Huq, PhD Student
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Supervisor:
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My name is Jo-Louise Huq. I am a PhD student at the University of Alberta School of Business. In this research I am focusing on how professions work together. When a complex problem is faced, different professions can be asked to work together so that different understandings can be considered. However barriers exist to working together in this way: multiple and potentially competing strategies can be brought forward, and it is often not clear which strategies should be chosen. We do not really know how barriers like this are overcome.

I would like to invite you to participate in this research to talk about your experiences working with other professions. The objectives of my research are twofold. First, I hope to understand what barriers make it difficult for professionals to work together. Second, I hope to understand how professionals cope with or manage these barriers. I will consider the different professions represented, their objectives, the organizational context, and other relevant factors; for example, governments, professional associations, and clients that can create policies or impose demands on professionals. I will use the information collected during this study to develop my doctoral dissertation and practitioner and academic research papers. I hope that the findings of this study will be used to improve work and organizational practices to make it less challenging for professionals to work together.

Study Procedures: I will be collecting data in the form of interviews, observations, and archival data over the next 18 months.

> *Interviews*. You will be asked to take part in 2 interviews over the course of the research study. Each interview will last approximately one hour, and will be digitally recorded with your permission. Interviews will be scheduled in your regular work location, during working hours. If you like I will provide you a transcript of your interview so that you can check its accuracy.
>
> *Observations*. Once or twice during the research study, I will observe your interactions with other professionals. A regular meeting will be used as the site of the observation. You will not be required to do anything other than your normal activities at this meeting.
>
> *Archival data*. I will collect archival documents that are created by the group of professionals (e.g. the design team) in the completion of their regular work activities.

Research reports and findings will be distributed to all participants electronically. Please let me know if you would like to receive these documents.

Benefits and Risks: You are not likely to benefit personally from being in this study. There will be no cost to you for being involved, nor will you receive compensation. There is a risk that you might feel

uncomfortable responding to my questions. You have the option not to answer any question I ask. Overall there is very low risk to you if you choose to participate in the study. By consenting to participate in you have not waived any rights to legal recourse, in the event of research-related harm.

Voluntary Participation: Your participation in this study is completely voluntary. You have the right to withdraw your participation and your data from the research study up until the time that I start data analysis. To withdraw you simply need to let me know that you do not wish to continue participating. If you withdraw, your interview data will not be included in the research study and observations that pertain to you will be removed from the data. I will remind you of the voluntary nature of participation at each interview and observation session.

Confidentiality & Anonymity: All names and identifying information will be disguised so as to protect your anonymity. You will not be identified personally in any transcripts, field notes, or reports developed from this research. The anonymity of the organization will also be protected. All data will be kept confidential. Hardcopy and electronic data will be securely stored, and only my supervisor and I will have access to the data.

Data will be stored for a minimum of 5 years following completion of my dissertation. At the end of 10 years electronic data will be deleted and hardcopy data will be shredded.

Further Information: The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta.

Any questions you may have about this study may be directed to Jo-Louise Huq at telephone number (780) 289-3510. Questions about your rights as a research participant may be directed to the University of Alberta Ethics Office at telephone number (780) 492-2615.

If you agree to participate in this research study, please contact me directly at jhuq@ualberta.ca or 780-289-3510.

Jo-Louise Huq (Ph.D. Student)
University of Alberta School of Business

Acceptance: I, _____, agree to participate in the above research study conducted by Jo-Louise Huq of the University of Alberta School of Business.

_____ _____ _____
Participant Signature Date

Please initial below for items to which you agree:

	Initial
I agree to be interviewed for this research project:	_____
I agreed to audio recording of interviews:	_____
I agree to be observed for this research project:	_____

APPENDIX B: DATA TABLES

Table 6: Part 1 Study data table: Categories, themes, action, and illustrative data.

Abstracted Category	Second Level - Theme	First Level – Action	Illustrative Data
Complexifying Work	Bundling	Linking addiction to other social policy problems in policy.	Taking action to treat addictions … will pay off in reduced crime and safer communities. (Alberta Government, Justice, 2007) Addressing root causes of homelessness is essential to ending homelessness … The challenges that contribute to homelessness – be it poverty, mental illness, physical illness, addiction, or others – [must be] effectively addressed to help Albertans achieve stability and to prevent homelessness. (Alberta Government, Human Services, 2008) [We need to] strengthen public health services that promote wellness … encourage Albertans to make healthier lifestyle choices … prevent and treat addictions. (Alberta Government 2007, business plans)
		Organizational bundling - linking addiction to mental health and chronic disease	We [AHS] are calling some people 'addiction mental health therapists' … one of our primary goals is we want everyone walking in the door to be assessed for addictions and mental health concerns and not just one or the other. Right from the get go if we call them 'addiction mental health therapists' that broadens their scope of practice, their responsibilities, and what we would like to see them doing. (AHS Director). You cannot treat just one condition [addiction or mental health]. You are not providing a service that will result in the best outcome. You need the presence of a multi-disciplinary team or a group of professionals in order to have the greatest impact. (Director, AHS). I manage the addiction program which includes the addiction center, which is a concurrent disorder program so addiction and mental health. (AHS, Manager)
	Disrupting simple framing	Developing, circulating, and using metaphors Circulating and using new metaphors in organizations and professional networks	[AFWI] has given us a common language to use across systems … it [has] helped us to think not of addiction or mental health as isolated phenomena but [as] linked quite closely to social policy, poverty. (Director, Alberta Health) We lead [education and training of professional staff] with addiction is a brain disease … the medical model … it is a disease … a life-long chronic disease … we really are educating people that this is …like diabetes. (AHS, Manager) We don't really need to talk about addiction [to clients]. We sure as hell don't need to talk about substances … it's so not the substance, or the addiction … [now we talk about] ... bad toxic stress. How are you responding to the toxic stress in your life? … How have you learned to respond to the toxic stress in your life? (Safe Harbour, Executive Director)
Boundary Work	Disrupting organizational and sectoral boundaries	Creating neutral ground to explore connecting opportunities Working collaboratively and in partnerships to design programs and services	Regional collaborative service delivery (RCSD) … brings different groups together …The ministries of Health, Education, Human Services work together. And then there's service delivery arms … school authorities … and Human Services CFSAs … and Alberta Health Services and Health [who] are working together to be able to coordinate and integrate and deliver supports and services … [in relation to addiction] there's a prevention promotion aspect but also potentially an intervention as well. (Alberta Education) We're invited … to tables now that are for the delivery of services for adults because youth has already done it [integrated addiction treatment with youth justice programs] … [We are sitting at tables for] persons with developmental disabilities, homelessness …transition planning, discharge planning. (Justice, Manager) We really need [addiction] services … [but] we needed a different approach … We [Human Services] needed to look at some better [addiction] prevention techniques. Focus on our vulnerable population … we brought together a group of people … from [Alberta] Health … [from] Children's Services, Human Services … a group [from the] community, not for profits … Education, Justice, all of the players to look at an action plan for youth. (Human Services) We have partnerships with the detoxes, Alpha Detox Society, Renfrew, Fort McMurray, Fort McLeod. We're going to the Lethbridge correctional facility in two weeks to meet with them about bringing people in. We have a strong partnership with Calgary Drug Treatment Court. (Simon House).

Abstracted Category	Second Level - Theme	First Level – Action	Illustrative Data
			We have Boyle McCauley Center involved [in the PCN] … another representative from the Calgary Counseling Center … we are quite involved with some of the non-profits around funding grants … though [non-profits] may not sit at our core committee we certainly are well connected to them. (AHS, Addiction and Mental Health SCN) We deal with Boyle McCauley Health Centre as well as Hope Mission and Herb Jamieson Centre, George Spady Society … Housing First … [we've] really established … network building and opportunities. (McCullough Center)
		Bringing addiction and mental health together in AHS	What used to happen is that addiction counselors would report to an [addictions] manager … what we instituted with the directors of mental health clinics and then the [addiction] managers is that addictions staff [in some sites] would report to a … mental health manager rather than an addictions manager. That's a big change. … I [no longer] have anything to do with those addictions counselors. … [The mental health manager] would be working with her team …[of] mental health therapists and addiction counselors. … We've done the same thing in [the addictions] detox center [that I manage] … we have a position for a mental health therapist and we are hir[ing] that position … on the addiction side, integrating mental health treatment into [addiction] service. [AHS Manager, speaking to changes in management between addiction and mental health]. We have moved within the zone to create a quality service planning umbrella. Under that we have … the social workers, the psychologists … each one of them have a number of initiatives underway … [in which] an integrated service delivery is identified as being a priority. (AHS, Director)
	Shaping an inclusionary boundary	Encouraging professionals to be more inclusive	In just the last few months we closed the number of possibilities we used to identify people as being either psychologist or social worker or an occupational therapist, and those jobs classifications have all now been described as a 'mental health therapist'. … One of our goals is we want everyone walking in the door to be assessed for addictions and mental health concerns and not just one or the other, so right from the get go if we call them MHT that broadens their scope of practice and their responsibilities. (AHS, Director) The history that an addictions counselor … takes is certainly as adequate and as comprehensive as the history that a mental health therapist takes. If they are both screening for all of the problems the person has, that's effective … there's this pool of common information that everybody collects. (AHS, Director) We've gained the most success and synergy from getting people to work side by side and having informal discussions … [they start to] say, 'I can see the way you work and I can kind of understand what you are doing' … you get [more] co-operation …when people get to know each other and experience each other's work (AHS, Director) [When we work on] process things [where] you can bring people together … whether its Quality Improvement or planning something or developing something … you start to pull out the commonalities. That's important in bridging divides. (AHS, Director). We [AHS] are … bring[ing] … mental health therapists into our youth addiction programs, we have been successful in getting some support through psychiatrists and through physicians … it helps bridge the two programs together. (AHS, Director) As part of the addiction program is the addiction network … nurses who work in consultation with physicians and are placed in the hospitals to provide consults for clients who have had addictions or reasons for addictions. [Addiction] may not be [the clients'] admitting diagnosis, so you might have someone who's had a heart attack but addiction is part of their history and they'll consult one of our nurses. (AHS, Manager) [South] Zone has done a lot of work [with the] physicians group … a lot of work to support the primary care networks. Because we want them to actually take our [addiction] clients back. So we are looking at how we get the family docs and clinics established so that … when a client's showing symptoms [physicians] would know what to do. [For example a] physician can fill out a basic referral form and identify key things and send it to Access Mental Health and Access Mental Health will follow up with the client. (AHS, Manager) Our system is set up intentionally to have [clients] referred [to addiction treatment facilities] … but that [referral process] really is a barrier for many clients. So [in some clinics we've] really tried to [encourage clinicians to see that] if the client's willing to go to the family care clinic [a primary care clinic], then bring [addiction] services to them. (AHS, Manager)

Abstracted Category	Second Level - Theme	First Level – Action	Illustrative Data
		Pulling addiction treatment into other sectors	We built a network with the Perpetual Offenders program. [Perpetual Offenders] are individuals that are doing a lot of crime … they're the runners for the drug runners … they're constantly being put in jail because [they are] being used or leveraged [by others] to perform … little criminal acts because they may have a mental health issue and they may be addicted to drugs. … In order to assist them, we work with the court, the drug court, and Perpetual Offenders program and we say, '… We're not going to put you [in] jail, but you're going to work towards [dealing with your addiction and housing issues in our center] … [our program] is a contingency around their probation order. (McCullough Center) We've had some difficulties [getting addiction and mental health assessments] for our clients … we just had a meeting actually with Alberta Hospital …. They had about 14 people came [to Drug Court] a couple of weeks ago. We [a now] actually have a[n AHS] person who is our right hand person. She actually attends drug treatment court every week. She comes to our pre court meeting. (Drug Treatment Court) Even though we are a non-medical detox, the guys that are coming here for detox have typically had years of substance use and are in bad shape … they all have huge medical needs. We incorporated a policy in our detox program that you have to go to the doctor within the first day or two of being here … we [were able to recruit] a doctor on board to help us. (Safe Harbour, Executive Director)
Temporal Work	Containing disrupting ripples with small local projects	Small disrupting projects	We recently got an increase … of 80 beds [at a hospital] … so we are developing an AMH unit of 20 beds … [and] we will be hiring addiction counselors. At [two tertiary hospitals] we've put addictions staff [into emergency departments] to have more multi-disciplinary teams there (AHS, Director, speaking to specific instances where addiction counsellor were introduced in to hospitals) Every week for two hours [our] clinical team comes together and … I would see a client and you would be observing from another room. And you would learn that way. As well as I would learn from you, because you might have questions or, you know, when I, so I see the person for about 45 minutes. [AHS, Clinic Manager, describing a clinic specific project implemented to help professional staff become familiar with each other's work] A project that the [AHS-SCN] is leading … looks at the issues around mental health and alcohol and drug use in a school setting … we ask kids, all kids in grade 8 through 12, questions around their mental illness and their use of substances. … It's a very strict research project so it has ethics approval … We're collecting data. We'll be in a position in the next little while to be able to share our year one results. (AHS, SCN) We changed [a vacated addiction counsellor] position from addiction counselor to family counselor, with addiction expertise. … [That] allowed us to hire someone who had some addiction expertise but who also could do mental health counseling … [and] part of their role is to build capacity with the other staff. (AHS, Manager) Typically individuals within mental health clinics have not been aware of motivational interviewing … that's often been used as language and treatment for the stages of changes as it relates to addictions. … We've recently put on two education afternoons or days around motivational interviewing for our mental health staff. (AHS, Director) I've asked my addiction team, through attrition, to hire mental health therapists rather than replacing them with an addiction counselors. Re-classify that position to mental health therapist in the former AADAC addiction clinics … What that means is that instead of [having] all addiction counselors [in the clinic the manager] has been able to hire a mental health therapist. … The addiction counselors, through supervision and getting to know this fellow, are understanding more about mental health issues … [AHS, Senior Manager] We did a lot of focus groups with the residents … looking at how we deliver services that would best suit their needs … if there was something going on around conflict, we would look at why that was happening. The guys would say, 'Well you know what? We know there's a gang member here'. … And then, we would say okay. Let's talk about that. And from there we built in resources … [for example] addiction counselors having groups on gangs and how they impact [substance use] … what are the rules of engagement around fellows coming from a gang environment? (McCullough Center, Director) A judge here for thirty some years … championed [the Drug Court] cause relentlessly. She was tireless in her efforts to get this program started … she managed to contact those in the know and those people who were able to assist with financing. She [got] this pilot project off the ground … a pilot project for a year … it kept getting extended. (Drug Courts)

Abstracted Category	Second Level - Theme	First Level – Action	Illustrative Data
			When somebody leaves a treatment center, they still don't know how to pay their rent, they still don't know how to do the laundry. So we address all of that stuff … in our life skills program we do parenting, we address budgeting, we address women's wellness, we address domestic abuse. It's all encompassing. When she's finally ready to leave here, she really has an understanding of what leads to [her] addiction and what … steps can I take to prevent that from happening. (Servants Anonymous Society) We added [to our main 12 step program a] job search skills … mood mastery which addresses depression without the use of medication … lifestyle components … doing light therapy, nutrition, sleep, socialization … money management that we're delivering on site with budgeting, credit and banking … talking about sexual health … workers' rights … (Simon House, Executive Director, describing programming changes).
		(re)Educating professionals in local settings	[StreetWorks] nurses do a lot of teaching at [hospitals and universities] … we talk to medical students, nursing students … correction students, social work students … paramedic students … EMT students. We talk to them about inner city health and the perspective people actually come with when they walk into a hospital … (StreetWorks) One physician described how, through his AFWI contacts, he has begun working with a corrections transitions team that facilitates the transition for individuals released from corrections facilities, often with just the clothes on their back. Instead of going to their "old haunts" after release, individuals come to the health center where he works, for wrap- around services. "Instead of there being a six-day gap between release and access to [medical] services, there's a four-hour gap." (AFWI Evaluation, 2014: 26)
	Avoiding disrupting shocks and ensuring future disrupting ripples	Future planning and connecting future projects to current projects	Tomorrow we [AHS-AMH] are supposed to have a meeting at the senior leadership level looking at decentralization of services, we will take a look at what are our opportunities right now. (AHS, Director) I'm talking to [a] Church … they are really interested in what we're doing and I'd like to go and strengthen that relationship … I'm debating on schools … I'm targeting those broader community supports that may not be thinking [about us] … they're not our partners that already know what we know …. [I'm] talking to them about brains and the brain story … to just shift people's thinking about … the Harbor House. (Safe Harbour) We fund … the distress center and the support network [counseling, brief assessment and intervention counseling and referral] … .we're going to link [our addiction prevention and treatment initiatives] to that … as well as to our bullying phone line … and eventually, within a couple of years, web based counseling … [we] will research [programs being implemented in other jurisdictions] over the next couple of years … we're already talking with them … (Human Services) We've approached the north zone to say that we're really interested in moving forward this idea of outcome and measuring outcomes [around addiction treatment] … [saying to them] we'd really like to be able to get at something that you're interested in … are you interested in understanding whether you're doing well or not? … We're currently in the north zone, because they're very interested [it's] … something that is of issue to them … [any project] … we do will be based on … a question that they have about the way that they're currently delivering services … of course each zone is different in their interests. (AHS, Strategic Clinical Network) We will be implementing an …integration advisory concurrent capable group … I have a[n] … education team … this education team will be available for our mental health clinics to build up capacity and knowledge around addictions … that will be happening over the next year to two years. (AHS, Director)

Table 7: Part 2 Study data table: Categories, themes, action, and illustrative data.

Abstracted Category	Second Level - Theme	First Level – Action	Illustrative Data
Configuring Work	Configuring space	Designing space	[Addiction services] was going to have their own file area. … We were going to share a waiting room and … we were going to share reception … but there were separate filing rooms … separate fax machines, separate e-mails, separate servers [until we were merged into AHS and no longer required separate file areas] … I can't remember when we first started planning [the clinic] …we planned for five or six years before they actually put a shovel in the ground. (Director, mental health, speaking to original plans for the clinic that were changed after the addiction and mental health department was created)
	Engineering the staffing model	Finding and hiring staff	You have to find somebody who is a fit … you have to really listen to … how do they work … not just what do they know, but how do you work? (Manager, addiction services) We designed a behavioral interview guide. 'Tell us about a time when you worked with a team?' … 'Tell us about a time, what happened, when you had a challenge with that team, how did you navigate it, what was the outcome?' … It is a newer [interview technique] … we used to [ask] … theoretical questions, or 'What do you know about this, or what do you know about that?' … and we forced answers … you can't just give a textbook answer … we want when you have had a problem. (Manager, addiction services, describing questions developed to interview new professional staff for Clinic A)
	Advancing a collegial relationship between management and professionals	Involving professionals in developing practice and participating in practice Sheltering professionals from external contradictions and inattention	We spent a lot of time in the first year and a half trying to shift paradigms … and trying to get people on board and engaged … [not saying], 'I'm a mental health therapist [or addiction counselor] this is my deal, I don't know what you do but this is my job description'. That's why we do the in-services, and that is why we did the retreat team building days. (Manager, addiction services) There is another activity we do together … the Compass Easy … it goes through different sections on how integrated are you …we went through the sections and rated ourselves as a team [and] we all have to come up with the same rating … we came together to complete the tool … and action plan. (Manager, mental health) This team … they don't really need to be encouraged or motivated to come up with quality improvement or things that would improve operations. They tend to come up with things on their own, and bring those ideas to [us, managers]. (Manager, mental health) In case conference, we have been really flabbergasted by the amount of individuals with history of trauma … 80% of the case presentations we are doing lately is trauma history, trauma history, trauma history. (Manager, addiction services, an education workshop about trauma informed practice was later organized for Clinic professionals) [Managers] keep us ...honest to those first three [SBPF] questions. (Nurse) [Managers] are in the case conference all the time … can give their feedback … suggestions [about] things that you did not think about. (Social Worker) The treatment plan [determined at case conference] gets ... the presentation format is signed off by a manager saying ok this client was discussed the treatment plan was agreed. (Social Worker) [We, managers and professionals] had started … looking at our addictions assessment tool, looking at the mental health assessment tool and saying ok what is essential, what are the main components that really guide our work. (Social Worker) we [managers] are at a point where we are going [to evaluate] our new assessment guide ... we are going to do a review of it and see how are we doing … What have we learned so far about using it … we checked through some [completed] files ... and we started to see who is filling out what sections, who is not filling out some sections, see what the comfort level is? And we are seeking patterns ... that helps us to say where do I need to empower them and give them more knowledge and to feel more confident to fill that out. (Manager, addiction services). Professionals call me … we run through the complete case from beginning to end. Take a look at the history … [we can] look at some missing information … I would [help] determine what other providers we could engage with this client, if this client needs to go to another level of care (Manager, mental health)

			[The other manager] and I are very open and transparent with what is going on in each side. We … talk to each other before we send messages to the staff (Manager, mental health)
Adapting Work	Redesigning activities of practice	Assessment	[Clients] … could be assigned to anyone of our clinicians and we tap into [others for help]. Let's say your specialty is addiction and yet [your client] also has some sever anxiety issues. [The professional] would keep [the client] on their case-load, but would consult with our other team [members]. Say, 'Ok, I'm working with someone with anxiety, what would you get as a recommendation from the mental health side?' (Nurse) As we went along it became important that you had another person, a different perspective, that you had two people looking at the same [client]. Then then we could come together and be like, 'Oh I thought this.' … 'Well, I got this, which is completely different,'. … It was amazing to see how different professionals' perspectives are when they are talking to the same person and are even in the same room at the same time (Social Worker) [Joint assessment] was to train [the addiction professionals] … to be more aware of what mental health things we need to look for. … We would watch the mental health therapist and see how they would question [clients]. (Psychologist) There were sometimes [during discussion] when you know they would [say], 'I don't see that as mental health that is just addiction coming out', and I was like, 'No … I'm not so sure about that' [and we would talk through how to move forward] (Social Worker) [Now] both sides are able to complete an intake assessment on the client. (MH Manager)
		Case conference	I'm not in their team conference … where they are discussing cases. (Psychiatrist) Every week we have a case conference where the whole team comes together and we present any new intakes … why they came here, what's going on with them, trying to portray … who this person is … what kind of treatment plan we came up with together. The other team members will ask questions around different things you don't necessarily think of … or if they just need additional information … if they have additional suggestions they throw them in (Social Worker) We switched over to strength based presentation … it goes along the lines of, 'This [age] female is special because …' The therapist or counselor has to list why [the client] is special. (Manager, mental health) How we approach [questioning other professionals] … is instead of asking, 'did you ask about this?' … instead of saying, 'did you ask her if her mom drank during the pregnancy?' instead of asking that way [we ask], 'did the mom drink during the pregnancy?' So we are not questioning whether [the other professional] questioned, we are questioning whether they have the answer. (Counsellor) They probably would not say it in that way that straight up. 'I don't think you are right.' It would be more like, Have you thought about this?' (Nurse) If you follow [the SBPF] then you really don't know why the person is coming in … we go through the [strength based] questions … then we have a segment where we go into the dirty details … very much focused on issues (Counsellor) The team's pretty good at communicating … I haven't seen it where [a professional has] not been open … to entertain questions further. They all understand that the purpose of case conference is to elicit feedback from your colleagues. (Manager, mental health) When we first started [case conference professional would say] … 'My client is on this medication, what does it do?'. I'll help in that education wise … I will say, 'This is what is happening. You know, you should look focus on this'. (Nurse) I notice that specific people will ask more questions along specific areas … they have specific preferences in addiction or something, so they will ask questions about that. … [A nurse] … knows more about medications so will ask more about … physical questions or medication questions. (Social Worker) In case conference I look around and listen to the clinical staff, they know each other's clients. When somebody is presenting … [the other professionals] are like, 'Oh yeah, I've talked to him, I know the one you are talking about' (Manager, addiction services)
	Re-designing tools used in practice		We don't have addiction files and mental health files ... it is a merged client file that we all share, it's all in one … we are all using the same interview guide, the same assessment guide, so it is not like, oh your SAGA, your mental health assessment, we are saying integrated assessment guide (Counsellor)

			We have devised our own [assessment] tool to address which issues and problems [clients] have so that's one [tool] that we devised as we went along … every client that comes in does not matter regardless of mental health or addiction we will do a checklist … that gives a quick overview of what their major issues are. (Nurse) I'm using [addiction's] charting system and [mental health] is using paper. So we have everything on our data base plus we have to have everything on paper … it's a matter of copy past print … but it is what it is (Counsellor)
Boundary Work	Trivializing task boundaries	Cross-training professional staff	[The professionals are] knocking on … colleagues door [frames] and saying, 'I'm stuck with this guy with anxiety. How should I proceed?' … There is a lot of informal … knocking … hanging out, 'I'm struggling with this client'. (AS Manager) I'll just walk into [the psychologist's] office and be like … 'Ok, you know this is going on with this client what do you think?' … You can just walk into their office, and then ask them, and get feedback. (Social Worker) [In the clinic] we are cross training the mental health therapists in providing addictions counseling and the addictions counselors are being crossed trained in some aspect of metal health's treatment [where scope allows]. (Manager, mental health) The biggest change for me has been about knowledge around medications and being able to see things differently. Like seeing if problems [in counselling success are related to] a change to medication. (Counselor) I've been looking at the mental health piece more comprehensively [since I joined the Clinic] … definitely putting more attention on that piece … (Social Worker)
		Peer support	There's a lot of support, peer support [between] different clinicians … someone will bring a difficult case and will say, 'I feel like I'm at my wit's end, I've done so much, I don't know what else to do, do you guys have any ideas?' And people will be very supportive … let them know that they've done all that they can. (Manager, mental health) [I cope with difficult clients] by having fun with my colleagues, joking around … checking in … we have some really tough cases, so bonding with them has helped. (Psychologist)
	Recognizing expertise and not hierarchy in the division of labor	Psychiatry and clinic practice	Sometimes you run into situations where a psychiatrist or a doctor will put the clients on a wrong med … I'll make a referral [to the psychiatrist] … (Counsellor) If [clinic professionals] felt a person [a client] needs to see a specialist, a psychiatrist, then they will make a referral … our interaction starts from there, after they make the referral (Psychiatrist) We will discuss with [the psychiatrist] what our concerns are before [clients] go in … usually [I will say] something [like] … 'I just can't quite put my finger on it, can you see if there is anything else?' (Social Worker) We can sit in on the consult and find out what the psychiatrist recommends (Social Worker) Our psychiatrist comes in every two weeks and her office is in there, and you … sit in [the] interviews. (Nurse) I make a diagnosis and then I make my recommendations … I would say you need this medication, or you don't need this medication, you need a course of behavior therapy, you need to be in a day program, you need to go to an additions program, you probably do need a residential program. (Psychiatrist) We brain storm [with] each other as to how you should approach a care plan (Psychiatrist) [Psychiatrists] come and seek us out ... and say, 'I saw so and so today. This is how they're doing'. … If I had a client go in for follow up then [the psychiatrist will] often come in and say, 'Oh so and so is doing really good, or when was the last time you saw them? Are they following up with you?' (Nurse) If [the psychiatrist] gives a mental health diagnosis … you also help them monitor the medication and see how that is going … because [the psychiatrist] is a consult so does not ever come back in and monitor … that is what we do. (Social Worker)
		Recognizing specialized expertise	Certain people have different perspectives … I talk to [the RN] a lot more about the medication piece because that's where ... his specialized knowledge is. (Social Worker) If I thought it [recommendations made by other professionals at case conference] was not a good idea, or wasn't fitting …then I would not do it. (Nurse)

			Specific people will ask questions along a specific area [expertise] (Social Worker)
	Absolving the expectation that professionals are problem solvers	Clients have strengths and goals	We really wanted to be client focused … here are some options that we've come up with, what do you feel comfortable with? (Counsellor) [The strength based approach] is really challenging … it's such a difficult way of thinking [and talking] about clients (Nurse)
		Solution seeking	I have a client … who was drinking lots but she wanted to work on trauma … I worked with her first to stabilize the alcohol [use] and then I referred her to [the psychologist]. To do a special type of therapy, to work on the [trauma]. (Social Worker) Mental health [and addiction] … it's really different because like you know … it's an ongoing problem so there is no cure to it. So our goal is to get you to your optimum level in the community (Manager, mental health) Sometimes [clients] may have quite a few issues going on … so to deal they turn to substances. Or maybe they have a mental health concern that they are self-medicating … it is very complex that way. There are a lot of things that factor in [and that makes it hard to solve problems]. (Social Worker) [Our goal is] to make [life] a little … bit better … ease their burden a little bit. (Nurse) They [clients typically stop coming to treatment because they] did not feel it was safe. They did not feel they got their needs met, they did not feel it was the right place for them. [I encourage professionals to]... just listen sit a listen to them and pay good attention to what [clients] are saying. (Manager, addiction services)