Creating Home In Community
The Social Construction of Normalization

by

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ABSTRACT

Deinstitutionalization of adults with mental disabilities has been occurring for years but was accelerated in British Columbia in the 1980's. Government policy on deinstitutionalization has led to the development of community living alternatives such as group homes. This thesis is an exploration of the social construction of normalization in group homes for adults with mental disabilities. Data from group home managers' work is used to explicate the social relations in their work through the constructivist methodology of institutional ethnography. The study analyses data from written policies and documents of the Ministry of Social Services and working documents of managers. The study explores how group home managers' competent managerial practice may accomplish 'normalization' but still leave something to be desired in the lives of both residents and managers.

It is argued that normalization in group homes following the Ministry of Social Services policy guidelines and official plans is constructed ideologically by managers in concert with other staff. Managers may feel dissatisfied with their efforts to normalize residents' lives, but managers carry out their work without understanding how their accountability practices are creating problems for them. Although successful as competent administrators, the discursive approach taken to policy implementation leaves managers (and staff) of group homes holding the bag for actual normalization and integration for adults with mental disabilities.

Where real barriers exist, they may never appear in the socially constructed accounts that managers generate.

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Chapter One

Introduction

During the past twenty years the disability field in Canada has seen a major increase in emphasis on human rights. People with disabilities are increasingly seen as a significant minority who have been marginalized in almost every area of life. Rights activists, such as the "Associations for Community Living" have for many years advocated for institutional closures and community living alternatives. Deinstitutionalization of adults from institutions in British Columbia has been occurring for many years, but was accelerated when the Ministry of Social Services announced in the early 1980's that all major institutions in British Columbia would close. Their policy on deinstitutionalization led to development of community living alternatives such as group homes. Group homes for adults with mental disabilities, who have moved from institutions to community have been established in Victoria, British Columbia.

My story is set in these group homes, where I was able to explore the work of managers. My first exposure to group homes for adults with mental disabilities occurred when Health Services For Community Living (HSCL) was established in 1993. This program is designed to provide professional nursing and rehabilitation services to adults with mental disabilities who live in group homes. I was partially responsible for implementing the nursing part of this program in the Capital Regional District.

My purpose in this thesis is to draw analytic attention to how group home managers' work is embedded in social relations of Canadian institutions and hierarchies. This embeddedness is something that I argue allows normalization in community living to be ideologically constructed. I contend that normalization in group homes looks much better on paper than it does in practice. I hope to demonstrate that ministry accountability processes coordinate and control managers' work, and both construct and mask the actuality of daily life in group homes. I contend that this ruling function perpetuates normalization as an ideological construct. When managers' work was analyzed as document based and organizationally relevant, their 'work' began to make sense. They 'produce' a version of what actually happens that, following normalization principles and Ministry guidelines, stands as 'normalized'.

I have spent much of my nursing career in supervisory and management positions, so I come to this research with knowledge of management functions and the nature of management work in organizations. An introduction to Marie Campbell's (1988) work prior to entering graduate school, challenged me to take a critical look at management practices. In her study of workload management tools, she argues that these strategies, in addition to assisting nurses to determine the right amount of staffing, also exercise management control of workload processes in ways that affects the care given. These strategies become data for decision making around managing nursing staffing budgets. These are the same type of management strategies which I, in my career have been part of developing and using.

Exposure to the work of Canadian sociologist, Dorothy Smith during my graduate studies provided me with a way of looking at how my work and indeed

other managers fits into a larger societal picture; how my practice may impact and in fact be impacted by larger, more general administrative processes. What interested me about Smith was that she proposed to examine social life in terms of how it is actually organized. How things happen as they do.

During the implementation of Health Services for Community Living (HSCL), I was introduced to the ideals of community living for adults with mental disabilities. Two or three years into the program I began to have questions about how and why some decisions were being made in group homes that may not, in my mind, have been in the best interests of residents. A family member of a resident voiced her concern to me. She said that residents of group homes for adults with mental disabilities were being taken out of the home every day to malls, day programs, and concerts when what some residents need is to stay home and rest. According to this family member, eating a meal can consume all a residents' energy. She fears that to group home staff, normalization and integration of residents to community means being out of the house every day. An HSCL nurse shared with me her concern about a group home resident who was unable to communicate verbally and whose medical status was considered fragile. Plans were underway by group home staff to take this resident up island to do some whale-watching. Due to his health status and the lengthy journey required, the nurse had questions about the choice of this activity. From my contact with group homes it seemed to me that managers had considerable control over what happens in these homes. However, during a meeting a couple of years ago, group home managers shared their frustrations related to an inability to obtain equipment for their residents in a timely manner. They discussed their concerns about not being able to meet residents' needs particularly when the government had indicated that resources would be available in community to do

so. This captured my attention. It seemed to me that managers have control over what happens in group homes, but now I was hearing that managers themselves could not carry out programming for residents. It was at that moment of differing perception that I realized that there was something in managers' work that prevented them from meeting resident needs. There was a disjuncture between the rhetoric of normalization and community living and the reality for managers and residents in group homes. Because of the puzzles that were forming for me, I wanted to explore the work of managers and discover what might be impacting their decision making and ability to provide for residents in the community. What does normalization in the community mean? How would the social organization of managers' work be structuring or influencing decisions that were being made for residents of group homes? I needed more information about managers' work and how it was organized.

My research data was collected from my own experiences and stories from managers about their work in group homes. My inquiry was designed to explore their work and explicate how that work was organized. The standpoint of managers in group homes was the entry point for this exploration.

I approached my project with a number of ideas gathered through a literature review which is discussed in Chapter Two. I needed to know how normalization and integration were conceptualized in the literature. Were there expectations of how such a concept could be implemented for people living in community? I also explore concepts of management and bureaucracy which have implications for the management of group homes. Exploring the concept of social relations and power was important, knowing that, as a manager myself, I

have control over some of my work but not all of it. Social Relations assists with exploring how managers understand and carry out their role as managers.

In Chapter Three I outline my methodology which was developed by Dorothy Smith (1987). Her research method called institutional ethnography, allows the researcher to discover the connections, the social relations which shape how work is organized but which are not visible to those doing the work. The benefit of this method is that it allows workers to see and understand how their work is organized.

In Chapter Four, I trace the development of deinstitutionalization of adults with mental and physical disabilities in British Columbia, and some organizational structures that were put in place to support community living. This provides the context for my study.

Chapter Five begins the data analysis as I explore policy documents and work processes of the Ministry of Social Services (MSS), Services To People With Mental Handicaps (SPMH) office. This is where official responsibility rests for residential services for adults with mental disabilities. I argue that normalization has been ideologically constructed by the ministry as a ruling practice, and that their rules and work processes maintain this. Specifically, I look at how documentary accounts are a key feature in organizing managers' work and residents' experience. Although normalization of residents' lives is the goal, the ministry's work of ruling penetrates, distorts and constrains what actually happens.

In Chapter Six I continue my analysis by examining data from managers' 'stories' which demonstrates the disjuncture between the ideal and the actuality of normalization in lives of adults with mental disabilities. I was able to explicate social relations of ruling implicit in their narratives and make explicit what controls their local experience. In this chapter I show how policies and programs have 'normalization' embedded in them, but ideologically. I demonstrate how managers' attempts to actualize normalization in residents' lives actually creates problems for managers and residents. These problem areas relate to issues around activities and social integration, acceptance into neighborhoods and purchase of equipment.

Chapter Seven concludes my analysis, where I look at what I have learned about managers' work. I contend that their whole work process is held in place by accountability requirements of bureaucracy. I touch briefly on the implications of my research findings for managers.

Chapter Two

Conceptual Framework - Literature Review

To begin looking at community living for adults with mental disabilities and the work of managers, I needed to explore the literature on topics which I saw as crucial to my study. In the first section of this chapter I define disability and discuss deinstitutionalization and normalization. I want to know more about normalization because it is assumed to be the philosophical base for community living. Community living for people with severe mental and physical disabilities is relatively new, however, people with mild to moderate disabilities have been living in the community for a long period of time. I draw attention to research, primarily from the United States, reporting outcomes of deinstitutionalization and community living for adults with mental disabilities. A report of particular interest to this thesis, however, is the study "Life in the Community" by Lord and Pedlar (1990) which is the first Canadian research to examine life situations of adults with mental disabilities who have moved from an institutional setting to living in community. It is a follow up to "Return to the Community" (Lord & Hearn, 1987), an in-depth report on the closure of Tranquille, an institution in Kamloops, British Columbia.

My experience has shown me that managers in group homes and government social services systems play a large role in how people with mental disabilities experience community living. Managers appear to have control over how group homes are managed on a daily basis and have significant input into decisions that are made. This is why in the second section of this chapter I was

led quite naturally into exploring the concepts of management, bureaucracy, power and social relations.

In the final section I look at concepts of powerlessness, oppression and empowerment and how these relate to managers' work with a marginalized population, those with mental disabilities. Empowerment might mean something different to management. Prior to going on to Chapter Three where I discuss my methodology, I end this chapter forming my research question.

Disability

The definition of disability I refer to is one used by the World Health Organization. According to the International Classification of Impairments, Disabilities, and Handicaps of the World Health Organization (WHO), a disability is "any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the stage considered normal for a human being" (Batavia, 1993, p. 735). In my contact with people with mental disabilities I have learned that they vehemently dislike to be called handicapped. According to Batavia (1993), the term handicapped justifiably has fallen into disrepute among people with disabilities largely because "it has been used improperly and pejoratively to refer to people with disabilities whether or not they actually are handicapped by their environment" (p.735). The group homes in my study have as their residents adults with severe mental and physical disabilities. In the Capital Regional District where this study takes place, the terms 'mental,' 'physical', and 'developmental' are currently used to refer to a person with a disability. However, written policies and standards of the Ministry of Social Services use the term 'handicapped'.

Deinstitutionalization

In this section I present a critical view of the concepts of deinstitutionalization and normalization as they apply to community living. Policy analysts and theorists in this field find it useful to distinguish between 'deinstitutionalization' and 'depopulation'. According to Philip Roos (cited in the foreword Novak, and Heal, 1980) the term deinstitutionalization has been generally adopted to refer to a three-pronged approach to decentralize residential services and improve quality of service provision. These three elements consist of: preventing institutional placements and minimizing length of placements; development of community-based residential alternatives; and improving institutions so as to better meet needs of those who can allegedly benefit from institutional placement. In other areas of Canada and the United States, improving institutions may be an option. In this region the priority is on preventing placements in institutions, deinstitutionalizing those already in institutions and providing community living options. Therefore, development of community-based residential alternatives is the element of interest to my study. Scheerenberger (1976) sees deinstitutionalization as "an attitude which places great emphasis on freedom, independence, individuality, mobility, personalized life experiences and a high degree of interaction in a free society" (Scheerenberger, 1976, p. 125). In contrast, Scheerenberger sees depopulation as "dumping" persons who have been institutionalized into the community with no planning or supports. This has happened in some areas, particularly with the deinstitutionalization of persons with mental health issues.

Scheerenberger (1976) has developed a critique of deinstitutionalization in which he turns the concept on its head, seeing in it a new form of institutionalization in the community. Institutionalization emphasizes group living, regimentation and accommodation, limited choice, lack of privacy, and minimal independence and mobility in a restrictive society. It has been associated with a 'medical model' in opposition to a 'developmental model' which places considerable emphasis on the psycho social dimensions of behavior. Scheerenberger (1976) points out that although adults with mental disabilities may no longer be physically in an institution, the emphasis in group homes may still be on institutional behavior. In contrast to institutionalization in the community, proponents of deinstitutionalization and community living talk about 'normalization'.

Normalization

Normalization is seen to be the philosophical base for community living. According to Emerson (1985), the ideology of normalization developed from a movement for rights of minorities to a consumer advocacy for rights of people with mental disabilities. Normalization had its roots in Scandinavia with Nirje and Bank-Mikkelsen, but it is Wolfensberger (1972) who defined it for North America. He defines normalization as "utilization of means (of community living for instance) which are as culturally normative as possible in order to establish, enable, or support behaviors, appearances, and interpretations which are as culturally normative as possible" (Flynn & Nitsch, 1980, p. 80). According to Wolfensberger and Thomas (1983), Wolfensberger and Tulman (1972) have added to this definition to say that normalization is "as much as possible the use of culturally valued means in order to enable and or maintain valued social roles for people" (p. 23). Consumers and advocates for people with mental disabilities

see normalization as important to the ideals of community living. In fact, normalization is, according to Lord and Pedlar (1990), "sometimes considered to be the ideological cornerstone of the deinstitutionalization movement" (p. 7). They say that normalization is widely acknowledged as having an influence on how community based services are structured. Does this hold true for the region in my study?

A major interest of this study of course is normalization and how it becomes operationalized in community group homes. Heal, Sigelman, and Switzky (1978) have outlined Wolfensberger's (1972) corollaries which are said to give direction to expectations of normalization for people with mental disabilities (Flynn, & Nitsch, 1980). Wolfensberger and Thomas (1983) have also identified 7 core themes of normalization. Because of the importance of this concept to my study, I will discuss these corollaries and themes using research on actual community living situations that examined these aspects of "normalization".

Prior to this discussion I list the corollaries and themes for easier reference.

Wolfensbergers Corollaries (Flynn & Nitsch, 1980, p.226):

1. Normalization requires cultural normativness of roles, expectations, forms of address, labels, environments, social services, and rhythms of daily, weekly, annual and lifetime activities.
2. Normalization relates to developmental as opposed to medical expectations, with people with mental disabilities being seen as growing individuals, not incurable invalids.

3. Normalization requires integration of activities and services, since segregation denies culturally normative opportunities.
4. Normalization requires continuity of activities and services with those of the mainstream of society when integration is precluded by circumstance or handicap.
5. Normalization requires a separation of individuals with disabilities and their services from one another, since congregation or juxtaposition impairs integration and thereby forestalls culturally normative opportunities.
6. Normalization requires smallness of served congregations for the same reason as found in corollary five.

Seven Core Themes of Normalization: Wolfensberger and Thomas (1983, p. 24-27).

1. The role of (un)consciousness in human services.
2. The relevancy of role expectancy and role circularity to deviancy-making and deviancy-unmaking.
3. The conservatism corollary to the principle of normalization.
4. The development model and the importance of personal competency enhancement.
5. The power of imitation.
6. The dynamics and relevance of social imagery
7. The importance of personal social integration and valued social participation especially for people at risk for social devaluation.

Wolfensberger's first corollary gives an overview of how all encompassing the expectation of normalization is. The corollary says that normalization requires

"*cultural normativeness* of roles, expectations, forms of address, labels, environments, social services, and rhythms of daily, weekly, annual, and lifetime activities" (Flynn, & Nitsch, 1980, p. 226). Has "cultural normativeness" of the normalization principle guided the way in which group homes are developed? Lord and Pedlar (1990) found several managers in group homes for adults with mental disabilities expressing their philosophy in normalization terms, however, they also found that group homes are not immune to institutional attitudes. In fact they found homes that were clearly institutional in nature vs. the few they found which they described as "enhancing or enabling" homes. In enabling homes there was consistency between group home philosophy and practice, a high degree of respectful interaction between residents and staff and there was resident participation in household activities (p.16). Obviously there can be contradictions between what people say and what happens in practice. Lord and Pedlar (1990) found in their research that this contradiction was consistent with previous analysis by Edelman (1977) that "the rhetoric and symbols of change often differ from what is actually happening in the lives of citizens" (Lord & Pedlar, 1990, p. 9). McCord (1982) proposed that this contradiction "is due primarily to the fact that social services are afraid of change, so that a commonly adopted strategy is to offer publicly an "illusion of change" (Lord & Pedlar, 1990, p. 9). In my study it will be important to see what is actually happening in the lives of managers and residents of group homes. Have services to people with mental disabilities changed from the institutional model or do we have in fact just an "illusion of change"?

In terms of the environment for people with mental disabilities, Baker, Seltzer, and Seltzer (1974) found a relatively marked influence of normalization in the physical facility in their sample of community residences. However in regard

to programs that were available for residents they found community residences placed considerable restriction on residents' behavior. Baker et al. (1974) also evaluated the degree to which community residential models met normalization ideals and found that apartments, and smaller group homes, met these ideals more than did the larger group homes, (Flynn & Nitsch, 1980). Gollay, Freedman, Wengaarden and Kurtz (1978) found that program features such as social development and independence, formation of social relationships and friendship ties, vocational options and leisure activities, needed considerable improvement (Flynn & Nitsch, 1980). This research indicates that physical living conditions had improved for people with mental disabilities, more so than psychosocial areas.

Wolfensberger's second corollary is related to "*developmental* (as opposed to medical) *expectations*, with the disabled seen to be growing individuals, not incurable invalids" (Flynn & Nitsch, 1980, p. 226). This relates to Wolfensberger and Thomas's (1983) core theme #4 which emphasizes the developmental model and importance of personal competency enhancement. Wolfensberger and Thomas (1983) suggest that "one of the most powerful ways for this to happen is to adopt the developmental model for service delivery" (p.36). I suspect this would mean that current programming and services would have to have significant emphasis on individual planning for each resident to meet their learning and developmental requirements.

Social integration for adults with mental disabilities is important to normalization. This notion relates to Wolfensberger's third and fourth corollaries: the "*integration* of activities and services, since segregation denies culturally normative opportunities; and the *continuity* of activities and services with those of the mainstream of society when integration is precluded by circumstance or

handicap" (Flynn & Nitsch, 1980, p.226). These corollaries relate to core theme #7 which stresses the importance of personal social integration and valued social participation, especially for people at risk of social devaluation (Wolfensberger & Thomas, 1983). It seems that for most people an instinctive response to a negative stimulus is to distance one's self from it. Because people with mental disabilities can be perceived by others as unpleasant, they can be rejected and kept at a distance, hence segregated. This may be one of the reasons for the development of institutions and why segregation seems to be a natural outcome of having a mental disability. It is therefore important to look at what kind of developing relationships residents in group homes have with family and people outside of group homes. Lord and Pedlar (1990) say that consistent with other studies (Gollay, Freedman, Wyngaarden & Kurtz, 1978; Malin, 1982; Bercovivi, 1983), they found residents of group homes had very limited networks in terms of unpaid support. People in their lives were all paid to be there. They suggest that this finding, when added to the high rate of turnover in caregiver staff, can leave residents of group homes with very fragile relationships. Lord and Pedlar (1990) also found that although parents of residents in group homes viewed deinstitutionalization of their family member as positive, there were varying degrees of extended relationships established. How then are people with mental disabilities being integrated into community?

Wolfensberger (1972) maintains that ultimately, integration is only meaningful if it is social integration, not merely physical presence in an environment seen as 'normal'. To Nirje (1976) integration means that relationships between individuals are based on a recognition of each other's integrity and a recognition of shared basic values and rights. When that recognition is absent, alienation, segregation and ostracism may result. He outlines six levels of

integration: physical, functional, social, personal, societal and organizational (Flynn & Nitsch, 1980, p. 47-49). In their follow-up study of residents in group homes, Lord & Pedlar (1990) found that residents were leading busy lives but were not integrated into community life. In terms of Nirje's (1980) six levels of integration, for the most part they found individuals had physical, functional and organizational integration in the way their lives were structured, but lacked social, personal and societal integration. Community integration did not appear to be the objective, but there was a need to keep people "on the go".

Lord and Pedlar (1990) suggest that managers in group homes have limited perspective on the concept and practice of community integration and social networking. They also suggest that residents in group homes will only expand their involvement in community life when service providers and families link individuals to natural social networks, to community clubs and associations, neighbours and the wider community. For example, a senior with a mental disability could join a seniors' group while a younger person may join a younger aged group. Implied here of course is that, in order for ways to be found to meet needs for social integration, people with disabilities must be seen as individuals with developmental needs. An important question to ask is what is limiting group home managers' perspective on the practice of community integration and the concept of social networking? Social integration is looked at further in Wolfensberger last two corollaries.

Wolfensberger's fifth and sixth corollaries address the need for: a "*separation* of handicapped individuals and their services from one another, since congregation or juxtaposition impairs integration and thereby forestalls culturally normative opportunities"; and "*smallness* of served congregations for

the same reason" (Flynn & Nitsch, 1980, p. 80). This relates as well to theme #3 which posits that "the greater the number, severity and /or variety of deviance's or stigmata of an individual person, or the greater the number of deviant/stigmatized persons there are in a group or setting, the more impact there is" (Wolfensberger & Thomas, 1983, p. 26). Devalued people have commonly been segregated away from valued role models in society. They have been: congregated with (other) devalued people who frequently have socially devalued characteristics and exhibit socially devalued behaviours; and are often served by less competent workers than typically serve valued people (Wolfensberger & Thomas, 1983). This congregation with devalued people works against theme #5 which points out that imitation is the most powerful learning mechanism known.

As I noted previously, Lord and Pedlar (1990) found in their study that the majority of group homes for adults with mental disabilities demonstrated institutional patterns of community participation. In institutional patterns they found: a contradiction between group home philosophy and practice; limited respectful dialogue between staff and residents; and residents' movements controlled with limited or no participation in household activities. (p. 16). This confirmed the initial findings in Lord and Hearn (1987), that neither agencies nor staff consciously structure or support relationships and expansion of social networks (p. 30). The staff in group homes did not seem able to bridge the gap between residents in group homes and community in terms of facilitating natural relationships. John McKnight (1994) suggests that when people with disabilities have been institutionalized or have services providing a lot of physical care by those who are paid to be there, they don't really belong in community. To address this problem he suggests that rather than going out in groups to day programs or sheltered workshops, people with disabilities need to be integrated

into community. Their capacities and gifts need to be capitalized on rather than their deficiencies, which is why he advocates, for example, for a person with a gift of singing, that a choir be found for that person to be part of. Of course, this kind of approach would require that individuals be planned for and attended to as individuals. Implementing this strategy I suspect could have implications for resource allocations and staffing patterns in group homes. There would need to be sufficient funding and appropriate resources available for this to happen.

Wolfensberger's corollaries summarize how he views normalization in the community. It seems that he has put forward 'normalization' as a set of conditions within which persons with disabilities could come to live in a more normative way. Wolfensberger (1972) is very clear that he is talking about normalizing the environment of people with mental disabilities, not the people themselves. However, a question to ask is whether the normalization principle is interpreted in the same way by all those connected with community living? Are there known problems with the normalization principle (Wolfensberger's) and community living?

Wolfensberger's analysis of the 'problem' with implementing normalization has a lot to do with changing 'attitudes'. By this I mean changing how society in general views people with mental disabilities. To elaborate further on this, Wolfensberger and Thomas (1983) describe the role of (un)consciousness in human services suggesting that people in human services tend to be unconscious of the extent that large numbers of people (society at large) can socially devalue other large numbers of people (people with mental disabilities). Wolfensberger and Thomas (1983) suggest that identification of the negative dynamics within human services that contribute to devaluation and oppression of certain groups is

a concern of normalization. To understand why normalization calls for creating "socially valued roles and life conditions for people" Wolfensberger and Thomas (1983) say that "a person can be considered "deviant" or devalued when a significant characteristic ("a difference") of his or hers is negatively valued by the segment of society that constitutes the majority or defines the norms" (p. 23). They point out that differences are not deviant if they are not negatively valued. They go on to say that because deviancy is culturally defined, then the door is open for devalued persons to acquire a more valued position in society. This can be done by preventing or reducing differences along with changing societal perceptions. Are societal perceptions and attitudes about people with a mental disability a problem in this region? If so, is there an impact for residents with mental disabilities in group homes or the people who work there?

Lord and Pedlar (1990) are more specific when they say that leadership is a key indicator as to how normalization is interpreted in community. In their study they found that how normalization was interpreted differed according to the leadership provided at both group home manager and service provider level. They also suggest that managers have considerable influence in how things are done in group homes. Staff consistently looked to them for guidance and confirmation. Lord and Pedlar (1990) say:

> "leadership is vital in development of effective human services. Managers of service systems and agencies are influential in processes of community living because they set expectations about staff functions and resource allocation"
> (p. 53).

Similarly, O'Brien (1987, p. 85), whose ideas are congruent with Heal, Sigelman, and Stitzky (1978), and Flynn and Nitsch (1980), points out that the

greatest barriers to community living are not inside people with severe disabilities or in fact the nature of community life but in the way necessary resources are organized (Lord & Pedlar, 1990). With regard to resources, Scheerenberger (1976) found that effectiveness of community living depends on the availability of local programs, support and guidance, which in contemporary society is highly dependent upon fiscal and regulatory policies of larger societal structures. Lord and Pedlar(1990) also suggest that "on the service system level, leadership is required to create expanded opportunities for innovation by individuals and agencies in regard to funding and resource utilization" (p. 53). But how is this done? Do managers of group homes have sufficient influence with regard to resource allocation and how resources are organized? Where do they fit in the organization of community living services? To gain more insight into this, a closer look at organizations, management and bureaucracy is helpful. These concepts will be discussed in the next section.

Organizational Theory - Management - Bureaucracy

In order to put this study into an organizational context, I define organization and discuss bureaucracy, management and management technologies. Throughout this section I continually ask myself how this literature applies to group home managers. Where are the connections? Where do they fit?

According to Robbins (1984) an organization is defined as "a systematic arrangement of people to accomplish some specific purpose" (p. 3). He says that organizations have three common characteristics: they have a distinct purpose, are composed of people and have developed some type of systematic structural arrangement that defines and limits the behavior of its members. Max Weber

(Robins, 1984) developed a theory of authority structures and described organizational activity based on authority relations. He describes an ideal type of organization that he called bureaucracy. Important to my discussion of organizations is the understanding of bureaucracy.

In Weber's (1948) classic theory of bureaucracy (Clegg, Routley, Dunkerly, & Paul, 1980), the defining characteristic of an organization was the presence of a leader and administrative staff, who were ordered and organized into specific types of social relationships depending on the type of rules to which action was oriented in the organization. According to Robbins (1984), bureaucracy to Weber was a system characterized by division of labour, a clearly defined hierarchy, detailed rules and regulations and impersonal relationships. Bureaucracy is not unlike scientific management in its ideology because both emphasize rationality, predictability, impersonality, technical competence and authoritarianism. Most contemporary organizations including the Ministries of Health and Social Services in British Columbia are organized in hierarchical bureaucracies. According to Weber, the emergence of this form of modern bureaucratic organization was necessary because the technical and economic basis of our culture demands this very calculability of results (Clegg et al, 1980). This is congruent with Marson (1991) who says that most organizations manage along a hierarchy in which management authority is centralized at higher and higher levels, and in increasingly specialized departments. In contrast, Osborne (1990), says "hierarchical, centralized bureaucracies simply do not function well in the rapidly changing, information-rich, knowledge-intensive society and economy of the 1990's" (Lynch, 1993, p. 4). This thinking represents a change occurring in organizational methods. Many writers are now suggesting that to be a workable society, those in management positions must lead as well as manage.

Leaders according to Bolman and Deal (1984) are able to see things differently, to have visions of new strategies or patterns in everyday thought. They are more than custodians of the status quo. According to Lynch (1993) though, sometimes people take no action because they feel powerless to do anything. "Laws, regulations, or policies mandate the status quo" (p. 10). Are group home managers able to provide leadership in community living services? What is their role in this?

Important to this study certainly is the role of managers. Managers work in organizations and direct activities of other people. According to Robbins (1984) management is defined as "the process of efficiently getting activities completed with and through other people" (p.15). It is important to note that:

> "although organizational outcomes are significantly influenced by the decisions and actions taken by management, these outcomes are also influenced by factors beyond a managers control. Constraints are often imposed on managers both outside and inside the organization" (Robbins, 1984, p. 13).

What is the nature of these constraints that are beyond management control? What is it that impacts management decisions? In attempting to answer these questions I look to the work of Ursula Franklin (1990).

Ursula Franklin (1990) defines technology as "involving organization, procedures, symbols, new words, equations, and most of all a mindset" (p. 12). She distinguishes between two very different forms of technological development, holistic and prescriptive technologies. She says that "holistic technologies" are associated with the notion of craft, for example, potters and weavers who control the process of their work from start to finish. This is specialization by product and their ability to make decisions and use their own

judgment is very important to the outcome. In contrast to holistic technologies are "prescriptive technologies" which is specialization by process. In this technology, the process is broken down into clearly identifiable steps. Each step is carried out by a separate worker or group of workers. This has also been referred to as "division of labor". Using the making of Chinese bronze casting techniques as an example of "prescriptive technologies", Franklin emphasizes "that understanding the social and political impact of prescriptive technologies is, in her opinion the key to understanding our own real world of technology" (p. 21). While with holistic technologies the work is controlled by the doer, with prescriptive technologies, control over the work moves to the organizer, the boss or manager. This is because this work is organized as a sequence of separate steps. According to Franklin (1990), the process itself has to be prescribed with sufficient precision to make each step fit into the preceding and following steps. Only by doing this can the final product be satisfactory and the outcome guaranteed. Individual judgment by a worker is eliminated. She argues that in political terms, "prescriptive technologies are designs for compliance and when working within such designs, "workforce" becomes acculturated into a milieu in which external control and internal compliance are seen as normal and necessary. Eventually there is only one way of doing something" (Franklin, 1990, p. 23).

Franklin (1990) argues that todays world is dominated by prescriptive technologies, but they are not restricted to materials production. They are used in administrative and economic activities and in many aspects of governance. While she acknowledges that prescriptive technologies can be very "effective" and "efficient" the downside is that we live in a culture of compliance and acceptance that there is only one way of doing "it". Franklin (1990) traces the spread of prescriptive technologies to the post Industrial Revolution period. She suggests

that "any tasks that require caring, whether for people or nature, any tasks that require immediate feedback and adjustment, are best done holistically. Such tasks cannot be planned, coordinated and controlled the way prescriptive tasks must be" (Franklin, 1990, p. 24). When successful, prescriptive technologies do give predictable results. They yield products in numbers and qualities that can be set before hand, and so technology itself becomes an agent of ordering and structuring. This seems to have some connection with Dorothy Smith's (1990) concept of "social relations" and relations of ruling, in particular. The ordering that prescriptive technologies has caused "has now moved from ordering at work and the ordering of work, to the prescriptive ordering of people in a wide variety of social situations" (Franklin, 1990, p. 25). The acculturation to compliance and conformity has in turn accelerated the use of prescriptive technologies in administration, government and social services. The same development has diminished resistance to programming of people. In relation to my study, I am interested in whether managers' work involves "prescriptive technologies" and if so, a) how are they organized so that they routinely and apparently invisibly penetrate it, and b) what is the impact on managers' work and lives of workers and residents in group homes?

The current trend to reducing the size of organizations and pushing responsibility downward is a direct assault on bureaucratic methods and mind-set that characterize life in most organizations. Freedman (1992) says,

> "managers are overwhelmed by too much information, too many rapid changes, and too many conflicting demands. Most see themselves within a 'system' over which they have little or no influence. They 'do their job' put in their time, and try to cope with the forces outside of their control" (Freedman, 1992, p. 33).

I wonder if this is how group home managers see themselves. If so, what impact might this have on residents. According to Senge (1990) the systematic inability to cope with complexity is a direct result of traditional scientific approaches to management. From a very early age, Senge notes we are taught to break apart problems, to fragment the world. This apparently makes complex tasks and subjects more manageable. However links between actions and results are infinitely more complicated than most managers suspect. Senge (1990) suggests that to understand the most challenging managerial issues requires seeing the whole system that generates the issues. "Systems thinking is the ability to understand the key interrelationships that influence behavior in complex systems over time, and should give managers the capacity of "seeing wholes". (Freedman, 1992, p. 36).

Where Senge identifies the need to see key inter-relationships that influence behaviour, Smith (1990) sees "relations of ruling" and "the governing processes of our society organized as social entities external to those persons who participate in and perform them" (p.15). Cassin (1993) argues that organizational systems operate routinely and that managers execute managerial technologies. Regardless of the intentions of those 'in' systems, routine practices carry ruling effects. Smith (1990) goes on to say that information about organizations is usually put into a framework of entities and organizational processes without asking how this is so or how does this come to be. In order to understand how work is organized I look to Smith's (1990) concept of "social relations".

Social Relations

Dorothy Smith (1990) derived the concept of "social relation" from Marx. She says that:

> "integral to a materialist analysis of social process, it (social relation) identifies the actual practices of individuals and their articulation in forming a social course of action. Different individuals, different individual courses of action, enter into relations through which they are organized vis-à-vis one another" (p.50).

Understanding "social relations" enables us to go from the moment of 'observation' in which a phenomenon becomes apparent to us in the here-and-now, and then moves to an analysis that "discloses how it is organized by and articulated to foregoing and subsequent moments in a social relation" (Smith, 1990, p. 151). This notion of social relation relates to our understanding of how everyday events are shaped by decisions and actions elsewhere and how everyday experiences are transformed into objectified forms of knowledge for the work of 'ruling'. According to Smith (1987) "relations of ruling" "is a concept that grasps power, organization, direction and regulation as more pervasively structured than can be expressed in traditional concepts provided by the discourses of power" (p. 3). Therefore, when Smith talks of "ruling" in this context she identifies:

> "a complex of organized practices, including government, law, business and financial management, professional organization, and educational institutions as well as the discourses in texts that interpenetrate the multiple sites of power" (Smith, 1987, p. 3).

She says that the organization of ruling is "extralocal", in that we are ruled by forms of organization vested in and mediated by texts and documents. The practice of ruling involves the ongoing representation of what happens in a local situation into the standardized and generalized forms of knowledge. In other words, what actually happens in the local situation seems to disappear into

standardized documents and texts in which it is represented for some official action.

Integral to Smith's (1990) ideas is that knowledge is socially organized. Texts are important to the social organization of knowledge. Written accounts stand in for the actual experience they claim to represent. Smith (1990) says that 'text' fixed in an official form is the same on each occasion that it is read. "Readers reading the final version are held to be reading the same text. Upon this depend the forms of organizational consciousness typical of contemporary bureaucratic and professional practice" (p. 75). This is where the everyday world of specific persons, and events gets translated into the language of bureaucratic and professional organizations. Of interest to my research is how the everyday world of managers and residents in group homes gets translated into organizational language for the conduct of social service systems. Does this translation differ from the everyday world? Campbell and Manicom (1995) say that "administrative practices can be explored as courses of organizational action that construct everyday life into something different from how it is experienced" (p. 8). An example is Mueller's (1995) research which explicates connections between marginalized women in Peru and work practices of professionals in Ottawa and Washington as well as that of intellectuals in university towns. She found that development projects misunderstood women's needs; in fact they 'constructed' accounts of needs that development projects could fill. She argues that these work practices "make rational the domination of north over south" (p. 99).

Smith (1987) begins research in the everyday world of experience but the social organization is only partially discoverable in the individual's daily

experience. She says that "insiders feminist materialism directs us toward grasping how our local and particular moments are entered into extended, generalized and generalizing social relations" (Smith, 1990, p. 204). Smith (1990) refers to "that total complex of activities, differentiated into many spheres, by which our kind of society is ruled, managed, and administered" (p.14). To relate this thinking to my topic, I can conceptualize that group home managers are performing part of this ruling and I can see from their descriptions of their work, its nature of ruling work as tasks. By examining the social relations in managers' work in group homes, it will be possible to see how their work of implementing community living ideals is organized, how it is as it is. Does managers' work in following ruling practices create problems for residents in group homes? How do managers interact within a system to provide a 'normal' home in community for their residents? What influence do they exercise in these processes? Managers are in the middle of organizational hierarchies and may actually have less authority over their group homes than I might assume. To increase my understanding I examine organizational power and authority, how it is exercised, as practical everyday activities such as work.

Power

Knowledge, organized for specific purposes, is the basis of power and control in contemporary organizations. Campbell (1988a) says "knowledge has always been the basis of rational administration and its organization and (managerial) control has been the basis of power exercised impersonally and officially" (p. 503). In her analysis of the development of a hospital patient classification system, Campbell (1988b) illustrates how use of a computerized information system gives managers control over nurses work. Information

generated by nurses is used to control workload processes and also as a way to manage nursing staffing budgets.

According to Campbell (1988a) Weber's classic analysis of bureaucratic administration has been expanded by Dorothy Smith who explores the textual and discursive nature of the exercise of power and control in contemporary organizations. Campbell and Manicom (1995) also see documentary practices central to the exercise of power in advanced capitalist societies. According to Campbell and Ng (1988) corporate management found its way into the state (government) sector in Canada in the 1960's as government began to use advice from the private sector (private companies and corporations) for reorganizing government decision making structures (p. 122). They suggest that availability of properly formatted information is key to modern management which explains why record-keeping has become an increasingly important part of standard management practice. Information systems require data from many sites to be sent to a central location. This data is then available for management to use to make decisions. In managing corporations, the advance of information systems meant that management could effect control at the level of production. By extention, it is possible this control could also be felt at the level of service provision in social service systems.

Management technologies, as was suggested by Franklin (1990) routinize much management decision making and actions based on them. Using computers to process and store large amounts of information that can be used for decision making removes historical reliance on individual managers to make the right decision. Campbell and Ng (1988) say that in the service sector, objective information replaces some professional judgment for management and clinical

decisions. For instance when quality assurance systems replace supervisory decisions.

> "Indeed, power is taken out of the hands of local managers who become responsible instead, for implementing and scrutinizing compliance with reporting systems. The local managers' part in the success of such programs is assuring the continuity and reliability of information flows" (Campbell and Ng, 1988, p. 123).

Campbell and Ng (1988) insist that "the routine use of document based management practices does more than provide accountability. The power implicit in such a management process is its capacity to authorize a particular viewpoint" (p. 123). The notion of 'ruling' that I am drawing out here relates to particular knowledge incorporating particular viewpoints that an information system routinely authorizes. Campbell and Manicom (1995) say that Dorothy Smith has insisted that:

> "by the late twentieth century, at least in Western industrialized societies, administration, management, and government are accomplished through work processes that rely on distinctively organized ways of knowing those aspects of the world that are to be ruled. Not only does ruling rely on specialized knowledge, but a central task of ruling is to organize and generate knowledge in a form that is useful for ruling practice" (p. 9).

Smith (1990) understands power as arising as peoples' actual activities are coordinated. In other words, power is not just out there. It is not an objective phenomenon. The role of knowledge in the exercise of administrative power is coordinative. She and others give many examples of how individual experience is replaced as people participate actively in accomplishing an objectified knowledge. "Objectified knowledge as we engage with it, subdues, discounts, and disqualifies our various interests, perspectives, angles, and experience, and what we might have to say speaking from them" (Smith, 1990, p. 80). As they carry out their administrative responsibilities, do group home managers create

objectified knowledge about residents? I want to explore if and how individual experiences of managers and residents are replaced by objectified knowledge. In my research, the analysis of work processes might uncover answers to these questions.

Smith (1990) gives an example of the power of case histories. Case histories are part of the knowledge base of professional discourse, as well as professional administrative practice. She says that case histories and case records evolved in the late nineteenth century city as "knowledge devices" when government welfare agencies and organizations were confronted with large numbers of people. They were part of a large development of administrative technologies which initiated contemporary forms. Smith (1990) says that:

> "Case histories and records are typically embedded in and integral to forms of organizations where the immediate and day-to-day contact with the people to be processed is at the front line and involves subordinates, whereas decisions about those people are made by persons in designated positions of responsibility who lack such ongoing direct contact" (p. 89).

Smith (1990) says that in organizations concerned with "processing people" there are particular forms or coordinating work processes that are focused on individuals, (i.e. adults with mental disabilities), who are their objects. When decisions need to be made, their "current status" is found in documentary pages which have peoples' past contained in them. For this research it will be important for me to explore organizational forms that surround adults with mental disabilities in social service systems and decisions made on the basis of this knowledge that affects their daily lives.

When Dorothy Smith (1990) speaks of 'governing or ruling' she is referring to:

> "that total complex of activities, differentiated into many spheres, by which our kind of society is ruled, managed and administered. It includes what the business world calls "management", it includes the professions, it includes government and the activities of those who are selecting, training and indoctrinating those who will be its governors" (p. 14).

She also says these are institutions through which we (nurses, social workers, researchers, managers etc.) participate in ruling. "Issues are formulated because they are administratively relevant, not because they are significant in the experience of those who live them" (p.15). Smith (1990) says that :

> "Our knowledge of contemporary society is to a large extent mediated to us by texts of various kinds. The result, an objectified world-in-common vested in texts, coordinates the acts, decisions, policies, and plans of actual subjects as the acts, decisions, policies and plans of large- scale organizations. The primary mode of action and decision in the superstructures of business, government, the professions and the scientific, professional, literary, and artistic discourses is utterance - verbal and more importantly, textual" (pp. 61-62).

The importance of documentary reality can be seen in Roxana Ng's (1988) study of immigrant women in the paid work force. Ng came to see how immigrant women were "produced" as a labour market category. She found on a day to day basis there was a tension between providing counseling services to these women and the increasing demand for producing documentary accounts such as payroll sheets, case records on the women, bookkeeping and other financial records. Ng argues that it was through documents that employment counselors organized and produced groups of women as particular kinds of women for labour markets. What is revealed in her analysis is "the extent to which the documentation process penetrated and organized the internal relations of the agency, both in sustaining the structural divisions among its members and objectifying counselors' relation to their clients" (Ng, 1988, p. 90). Texts and documents are seen as the general mode of ruling in advanced capitalist societies. Campbell's (1988b) study

of child protection workers is an example of exercising power and control administratively, through the use of knowledge. She found "the ideological construction of information rendered child protection workers actions subjectless, so that they could be categorized, quantified, measured, objectively managed, and brought into line with central policy objectives" (p. 516). Reviewing this literature I see how managers, like child protection workers may be tied to a process which objectifies residents in group homes.

In my study, I am interested in learning about documentation processes that are required of managers and how these processes influence managers' work. According to Ng (1988), given a certain funding and accountability relation, a ruling standpoint is built into systems that managers try to operationalize regardless of their personal beliefs or values. Campbell (1988b), says that "feminists have insisted on an experiential grounding of objective accounts because they see domination and oppression being organized through official channels, on the basis of objective knowledge" (p. 516). This leads me to wonder how much control managers in group homes have over their work and how they operationalize normalization. To what extent do they have the capacity to 'normalize' their residents' lives? How tied are they to simply executing routine technologies? Given the expectations that people have of them, managers in group homes may be in a very demanding and uncomfortable position. This raises questions related to powerlessness and empowerment in the lives of both residents and managers.

Oppression - Powerlessness - Empowerment

In this last section, I present ideas from the literature on oppression, powerlessness and empowerment. Watson (1993) says the motivation for

'womens' and 'disability rights' movement(s) is similar in sharing characteristics, such as oppression, denial of rights etc. Empowerment is seen by many as the process of people reducing their level of experienced powerlessness and alienation, and gaining control over all aspects of their lives and environment (McKenzie & Wharf, 1995; Wheeler & Chinn, 1991; Rose & Black 1985). According to Rose and Black (1985) in order to understand empowerment it is necessary to look at oppression, and recognize that not only people with disabilities are oppressed but oppression can also apply to caregivers whether they are paid, family, or professional. Bullock (1993) talks about the politics of care, how oppression of people with mental disabilities leads to oppression of women as caregivers, with proliferation of new low paid jobs for women such as community support workers in group homes.

At the center of Paolo Freire's (1982) work is the concept of struggle, or working to transform reality from its present oppressive, exploitive conditions to circumstances which allow/demand dignity, social justice, and meaningful participation of people as human beings. This is what normalizing lives of people with mental disabilities is all about. When people in the disabilities field talk about 'normalization' they are probably meaning measures that make the lives of people with disabilities more like the rest of society. Friere's teachings for social activists were also concerned with this goal. Freire's way of expressing this is to talk about the difference between people as subjects versus people as objects. Freire (1982) says "objects are known and acted upon and subjects know and act". From the lives of people with mental disabilities, we can reflect on Freire's comment, "in order for the oppressed to be able to wage the struggle for their liberation, they must perceive the reality of oppression, not as a closed world from which there is no exit, but as a limiting situation which they can transform (Freire,

1982, p. 34). A prerequisite step for an empowering process is to build enough support for people to allow them to show us how they perceive the world (Rose & Black, 1985). This is treating people as 'subjects' in their own lives rather than objects of administrative action.

Management as I am discovering in the literature is an objectifying practice. Managers and community support workers in group homes for people with mental disabilities work with adults who have historically been oppressed. As I understand more about the social organization of administrative power I begin to see that individuals working with people with mental disabilities could feel powerless as well. Will the focus of normalization in group homes become an empowering process for residents, managers and staff? Will this be an outcome of community residential care? This may well depend on the organizational context in which normalization in group homes take place.

Throughout the literature review my thinking has centered around the notion that managers work within a certain context. Their work with adults with mental disabilities is within a defined social service system and therefore their work is in an organizational structure of social relations of ruling. I am interested in knowing: what is the work experience of group home managers; where does their work connect with others; and how is their work organized. I want to know if they are accountable and if so whose interests are being served. To address these research interests I have developed the following research question:

Research Question

Exploring the work of managers in group homes for adults with mental disabilities, I want to understand how their competent managerial practice may accomplish 'normalization' but still leave something to be desired in the lives of both residents and managers.

Chapter three

Conceptual Framework - Methodology

I have chosen a research method within the constructivist paradigm or qualitative methodology as the basis for my study. Qualitative methodology of this sort "stands on the fundamental premise that the social world has no existence independent of the activities and understandings of those participating, including the understanding and activities of the researchers" (Jackson, 1991, p.1). The choice of methodology relates to my beliefs about the nature of reality and how we can know about the world. I am curious as to why organizations and people are the way they are. I want to know more about how things work, and how things happen to us the way they do. The goal of my investigation is to study the 'work' of managers in group homes for adults with mental disabilities. It is not designed to test a hypothesis but to build knowledge of how work is organized, how it relates to managers' ideals about home like care. Having idealist goals, as most group home managers do, I am interested in how their work does or does not lead to desired outcomes. What makes the difference?

The research approach I am using is situated within Smith's (1987) studies of the social organization of knowledge. The emphasis here is knowledge "as socially and materially organized, as produced by individuals in actual settings, and as organized by and organizing definite social relations" (Smith, 1990, p. 62). The social organization and accomplishment of knowledge itself is the focus of the inquiry. Smith (1987) has interests that are important to my study. She is curious as to how knowledge can exist independent of knowers; how socially

organized practices of knowers can obliterate their presence as subjects from the objectified knowing we call knowledge; and how a knower, embodied and situated in a local and particular world participates in creating a knowledge transcending particular knowers and particular places (p. 62). I also have similar interests as my study relates to managers and residents as knowers in group homes for adults with mental disabilities. To investigate these interests is to enquire into the social organization of knowledge. To do this, I am using a methodology called Institutional Ethnography.

Institutional Ethnography

Institutional Ethnography is a feminist and qualitative research method developed by Dorothy Smith (1987). She uses the terms "institutional" and "institution" to identify:

> "a complex of relations forming part of the ruling apparatus, organized around a distinctive function --education, health care, law and the like. In contrast to such concepts as bureaucracy, "institution" does not identify a determinate form of social organization, but rather the intersection and coordination of more than one relational mode of the ruling apparatus" (p.160).

The aim of her approach is to explicate actual social processes and practices that organize peoples' everyday experience from a standpoint in the everyday world. She proposes an inquiry intended to disclose how people's everyday experiences are organized and determined by larger social and economic processes. Relating this to my interest, I wonder if the work of group home managers is also organized by these larger processes? Smith (1990) suggests that "we are not after the "truth", but that we want to know more about how things work, how our world is put together, how things happen to us as they do" (p.34). This is key to understanding institutional ethnography. Smith (1987) sees this as essential

because "if we don't examine and explicate the boundaries set by the textual realities of the relations of ruling, their invisible determinants will continue to confine us" (p.65).

In doing this type of research, I am working from specific assumptions. Campbell (1996) in a recent paper, reported on an organizational research study in which she uses institutional ethnography. The assumptions she outlines are those that I am working with. They are:

1. That organizational knowledge is text-mediated in contemporary organizations.
2. That a setting known through special texts may appear different from how it is known experientially.
3. That the power of subordinating local experiential knowing to the discursive is the basis of textually-mediated management or ruling.

(Campbell, 1996, p. 4-5.)

Smith (1987) proposes that the standpoint of women is one that is outside textually mediated discourses in the actual experience of their everyday lives. She developed her research approach to explore the particular needs of women and argues that "the only way of knowing a socially constructed world is knowing it from within" (Smith, 1987, p.22). The movement of Smith's research is from a woman's account of her everyday experience to exploring "from that perspective" the generalizing and generalized relations in which each individual's everyday world is embedded. She maintains that the determinants of woman's daily experience are not to be found in that experience, but elsewhere in the political, social and economic order. Campbell and Manicom (1995) note that in a variety of sites,

> "everyday experience is transformed into objectified forms of knowledge for the work of ruling but also how everyday experience is an entry point into how ruling works. In this kind of research, experience has both conceptual and methodological centrality. Its methodological importance is that 'experience' provides a standpoint, a place to begin an inquiry and a place to return to demonstrate its usefulness" (p.7).

I begin my inquiry from the standpoint of managers in group homes for adults with mental disabilities. It was their job to mediate government rules for group homes and to handle issues that arose in residents' lives. Managers were there and were involved. According to Smith (1987), a standpoint in the everyday world "distinctly opens up for exploration the conceptual practices and activities of the extra-local, objectified relations of ruling as what actual people do" (p. 28). Beginning with managers' experience enables me to see their work processes that come to be reportable. It is also a place to return to. Smith (1987) maintains that researchers must be very clear of the standpoint from which they are doing the research and stay grounded in that standpoint. Therefore it is important for me to stay grounded within the managers' accounts of their everyday experience and explore from that perspective, being alert not to take up the perspective of the governing organization, the Ministry of Social Services.

Smith (1990) uses the term "line of fault" to describe the situation where everyday experience and accounts made for ruling purposes are not the same. George Smith (1995) argues that this occurs when "the ideology of the politico-administrative regime is ruptured, when people know a situation to be otherwise on the basis of their everyday experiences" (p.20). Dorothy Smith's inquiry into the problematic of the everyday world is best understood according to George Smith (1995) as an effort to extend her knowledge as a member of this world to understanding its extra-local forms of social organization. Dorothy Smith (1990)

says the governing processes of our society are organized as social entities external to those persons who participate in and perform them. In group homes for people with mental disabilities I saw a line of fault or disjuncture between what was everyday experience for residents as opposed to what was described by proponents of community living and what I read in government documents. Both were understood to be 'normalization'. Indeed, managers were clear that their work was addressed toward normalizing residents' lives, and achieving program goals. Puzzling for me was why certain decisions were being made on behalf of residents which may not necessarily have been in their best interests. Managers' experience was used as my point of entry to explore the extra-local coordination of their work. These explorations and my analysis were used to explicate social relations in the work of managers in group homes by tracing the extra-local organization of their everyday experience and decision making.

Institutional ethnography's method of beginning with the everyday world as problematic is different from the empirical scientific approach to understanding "general" relations that organize events or experiences. According to Dorothy Smith (1987),

> "the relation of the local and particular to generalized social relations is not a conceptual or methodological issue, it is a property of social organization. The particular "case" is not particular in the aspects that are of concern to the inquirer. Indeed, it is not a "case" for it presents itself to us rather as a point of entry, the locus of an experiencing subject or subjects, into the larger social and economic process. The problematic of the everyday world arises precisely at the juncture of particular experience, with generalizing and abstracted forms of social relations organizing a division of labor in society at large"(p.157).

Using a feminist perspective, which I see as a standpoint outside textually mediated discourse, my study explores how managers' work in group homes, from their account of their everyday experience, is itself organized by features of

organization outside their control, i.e. policy, regulations, funding etc. Smith (1987) says:

> "Rather, sociologists' investigation of our directly experienced world as a problem is a mode of discovering or rediscovering the society from within. We begin from our own original but tacit knowledge and from within the acts by which we bring it into our grasp in making it observable and in understanding how it works. We aim not at a reiteration of what we already (tacitly) know, but at an exploration of what passes beyond that knowledge and is deeply implicated in how it is" (Smith, 1990, pp. 23-24).

According to Smith (1987), "institutional ethnography explores the social relations individuals bring into being in and through their actual practices. Its methods whether of observation, interviewing, recollection of work experience, use of archives, textual analysis or other are constrained by the practicalities of investigation of social relations in actual practices" (p. 161). She notes however that institutional ethnography as a way of investigating the problematic of the everyday world does not involve substituting the analysis, the perspectives and views of subjects for investigation by the researcher. In my study, managers are indeed expert practitioners of their everyday worlds, Smith's notion of everyday world as problematic assumes that disclosure of extra-local determinations of their experience does not lie within the scope of everyday practice. "We can only see so much without specialized investigation, and the latter should be the researcher's special business" (p. 161). The managers will not be able to see social relations within their daily practice. It will be for me, the researcher to explicate.

A constructivist stance assumes the engagement of the researcher. Dorothy Smith's (1990) institutional ethnography methodology requires the researcher to move from an objective to a reflexive stance where the researcher inhabits an actual world, the social organization which she is involved in "investigating". According to Smith (1990) "we may not rewrite the others world

or impose upon it a conceptual framework that extracts from it what fits with ours. Their reality, their varieties of experience, must be unconditional datum. It is the place from where inquiry begins" (p.25). I, as researcher have responsibility for faithful representation of data collected.

My research interests include the textually mediated administrative practices that make the work of group homes accountable. What documents might managers be required to use? Marie Campbell (1995) shows from her field research how current theory-based nursing education prepares students to be competent practitioners of what she calls "accountable" rather than "care-centered" nursing. Students in the program she studied learn, she argues, to construct the appearance of adequate nursing in documents. Organizations' relations are at work in accounts of their work. "Work is connected to organizational courses of action which are themselves outlined step by step in documentary form as policies, directives, and legislation" (de Montigny, 1995, p. 217). It will be important for me to discover how government accountability strategies impact managers' work. Dorothy Smith proposes an inquiry that "begins with the text and investigates the actual social organization which structures the relations between knower and known" (Campbell, 1995, p. 222). In other words, exploring the coordinating properties of texts leads to an explication of how everyday life is organized. I will be looking at the accountability of managers in group homes to ruling organizations. Part of their experience will be textual, which is how ruling is done and decisions made. In my research, I have to make sense of settings on their own terms. In reading documents, an important assumption is that a document has an intended reading that is reflexively related to the forms of social organization it helped coordinate. Following George Smith (1995), I will be reading documents not just for their

meaning, but for how they organize peoples lives. I will be reading them to reveal the organization they coordinate which provides access to the social relations of managers' work. So in order to understand the settings both observations and texts will be analyzed

In qualitative research the ability to embed descriptions of people's activities in a wider set of social relations depends, as George Smith (1995) points out, on an important ontological property of social courses of action - their recursivity. This ontological property of social relations makes it possible in examining a particular instance at a local level, to move to a description of a general form of organization, to social relations as a general course of action coordinated by texts. Methods of traditional "objective" sociology depend on the procedures of inductive statistics to accomplish this level of generality (Smith, 1990). In my research it could be possible to generalize the findings from group homes that are studied and assume that where the social organization was the same, findings about the homes would also be similar. I can make a claim for what is generalizable on the basis of social organization that is general, i.e. the procedures that govern.

The Study

My initial exposure to the work of managers in group homes for adults with mental disabilities occurred in the summer of 1993 with the implementation of the nursing part of Health Services for Community Living (HSCL) in this region. As I said previously, HSCL is a provincial program which has registered nurses and rehabilitation therapists responsible for providing professional support to adults with mental disabilities living in group homes. The implementation of this new program required my participation at meetings with Ministry of Health

staff, the Administrator of Glendale Lodge and family representatives. It also included meetings with the provincial HSCL Manager, and the Nursing and Rehabilitation Consultants. Following recruitment of nursing staff to work with HSCL, I attended an intensive five day provincially organized orientation to introduce nurses (and therapists) to their new role. In addition, as part of orientation to my own region, I spoke with family members of adults with mental disabilities and visited several group homes to provide myself with a 'picture' of the work that nurses would be doing.

Although I had gathered stories from HSCL nurses and family members of residents in group homes during the course of my regular work, the major portion of my data was collected from January to March of 1997. To learn about the work of managers in group homes for people with mental disabilities I conducted interviews with three managers and undertook two participant observation experiences in group homes. Two managers interviewed were selected by the Chief Executive Officer of their Service Provider Agency, so I could make the assumption that I was directed to perhaps what could be seen as the best group homes in their agency. The third manager I had met on previous occasions related to my work and this manager agreed to participate in this study. The first interview took place in my office. This was requested by the manager so that we would be able to concentrate more easily and not have interruptions that the manager thought might occur if the interview took place in the group home. This fit with the intent of my ethics review where I stipulated that interviews would be at a time and place that worked best for managers. Therefore, all interview times were selected by managers. The second interview took place in a group home one morning over a three hour period. During those three hours I was able to interview the manager and also complete an observational experience. This

experience included my observing staff prepare group home residents for their "day program". As their day program required them to travel to another residence I was also able to accompany them on that journey. The third interview took place in a group home one morning and lasted two and one-half hours. The second participant observational experience took place during the early evening over about one and one-half hours. I needed to spend time with managers in their group homes in order to obtain some sense of their everyday world. The interviews were audio tape recorded. I also made field notes during the interviews and following observational experiences. A research information sheet (Appendix A) and separate consent form (Appendix B) were reviewed with the managers. Approval from the University of Victoria Human Subjects Committee was obtained for this study.

My work reflects the time period I have identified and my analysis is based on experiences reported by managers at that particular time. This data provided me an entry point to my study. Using interviews and observational techniques I gathered stories from managers and explored ways in which their stories could be understood by examining the extra-local coordination of managers' work. The managers' stories and my observations of their work led me to an extensive review of Ministry of Social Services documentation and an interview with Ministry of Social Services (MSS) supervisory staff.

Managers' stories led me to a review of their work with respect to normalization as it appears in MSS documents. The documents I analyzed helped me make sense of managers' stories about their experience. The line of fault which emerged between the discourse of normalization as it appears in ministry

documents and the experience of managers is discussed extensively in the chapters of data analysis.

My work is not an evaluation of the work of managers or residents in group homes. It is not about what is good/bad, or right/wrong, or what I saw that works or does not work in group homes. What I will say though, is that during my meetings with managers and during the observational experiences, I did make some personal observations. I observed that the managers and group home staff that I met care passionately about the welfare of adults with mental disabilities. These are people who have the most honorable intentions of making normalization in community living a reality for residents in group homes. They want these residents to have a normal (quality life). This study is about my interest in understanding the work experience of group home managers and discovering how that work is organized. The managers were telling their stories as it was for them, which is neither right or wrong, but how they understand and conduct their work.

Prior to beginning the data analysis I outline in the next chapter the context of my study. I begin with a history of deinstitutionalization and discuss the development of community supports and services in group homes for adults with mental disabilities.

Chapter Four

Policy into Practice.

In this chapter I give the wider context in which my study is situated. I begin by tracing the development of deinstitutionalization in British Columbia, and some of the structures that were put in place to organize services for community living. I also explore the part played by families and associations for community living.

Deinstitutionalization In British Columbia

People with mental and physical disabilities have until recently been institutionalized in British Columbia as elsewhere. Institutions themselves, however, have only been a concept since the 1800's. In the 1970's two trends combined to break down disability policy consensus and prompt reform. First, the rise of self-advocacy by people with disabilities or their advocates (independent living movements) at the national, provincial and local level challenged professional dominance of service programs. Second, there was the issue of rising costs associated with care of this group in institutions. In addition, the human rights movement provided support and increased awareness on the part of the larger society of the rightness of community living for all. From 1973 to 1983 there had been significant thrust toward deinstitutionalization in Canada and British Columbia. As early as 1975, the Canadian Association for Community Living (CACL) had policy positions concerning zero admissions to institutions and a process for deinstitutionalization (Lord & Hearn, 1987).

In the 1981 Throne Speech, the government of British Columbia made a commitment to develop increasing supports and services in local communities for people with disabilities and to eventually phase down larger institutions as they existed at that time. To this end, in 1983 Grace McCarthy, Minister of Human Resources (the name of this ministry was changed to Ministry of Social Services (MSS), and then in 1996 has changed again to the Ministry of Children and Families (MCF)), announced that Tranquille, an institution in Kamloops, British Columbia would close within two years. To complete closure of the two remaining large institutions, in 1987 the provincial government announced its intention to close both Woodlands in New Westminster, British Columbia and Glendale Lodge in Victoria, British Columbia. This announcement was made in order to return all people with mental disabilities to their community of choice or origin, to be with family and friends regardless of intensity or severity of their health care or behavioral needs. While in 1981, 55% of people with mental disabilities in British Columbia lived in institutions, by 1992 it was less than 8%. This has been further reduced by the closure of Glendale Lodge (March, 1996) and Woodlands (December, 1996).

Announcement of these closures must be seen in the context of trends previously identified. Normalization and community living have increasingly become accepted as "guiding ideology" for services for people with disabilities (Lord and Hearn, 1987). In addition, the era of fiscal restraint that swept over British Columbia and other parts of Canada in the early 1980's seemed a further impetus to accelerate deinstitutionalization. Capital and operating expenditures for institutions were enormous and increasingly governments and advocates saw economic benefit of community living. (Lord and Hearn, 1987).

Implementation of community living policies for various institutional populations has been supported by conservatives who see this move as a step toward reducing government involvement and spending in social welfare areas. It also is supported by liberals who argue that community living restores basic rights which residents of institutions are often deprived. Behind the rhetoric of Grace McCarthy, Minister of Human Resources, the message was clear. Institutional closures are cost effective and would allow government to reduce civil service, which was the mandate of all ministries at that time. This was clearly part of a neo-conservative ideology introduced by Social Credit Government which included restraint and privatization. It really 'framed' the course of this policy which was tied to firmly held values and ideologies of government.

Deinstitutionalization policy is an example of a "forward mapping" (Wharf & McKenzie, 1995) approach to policy making. Key players inside government who were involved with Cabinet in deciding to close institutions were the Minister of Social Services and a small number of civil servants. Government did not involve outside groups in any kind of consultation process either before or after the announced closure. Lord & Hearn (1987) studied the closure of Tranquille, a large facility for adults with mental disabilities in Kamloops, British Columbia. They found that Ministry of Social Services developed and clarified some definitions of key issues and values of deinstitutionalization. However, these were neither widely understood or distributed. The outcome was that some Ministry of Social Services regional staff felt out of touch with the closure goals. Another group which felt out of touch and frustrated with outcomes of the Tranquille closure was the British Columbia Association for Community Living (BCACL) (Lord & Hearn, 1987). To understand this, a closer look at this association is helpful.

British Columbia Association For Community Living

British Columbia Association for Community Living (BCACL) is a formal voluntary advocacy group with a 40 year history of advocating for people with disabilities. Associations for community living, such as the Victoria Association For Community Living (VACL) are registered non-profit societies who receive part of their funding from government. It is generally acknowledged by those associated with adults who have mental disabilities that pressure from the British Columbia Association for Community Living (formerly called British Columbians for Mentally Handicapped), and a strong parents group from Woodlands provided a great deal of pressure on government for changes to living conditions of these adults. According to Wharf (1992), the philosophical base for Association for Community Living work is the principle of normalization. The legitimacy of BCACL and national acceptance of the principle of normalization proved potent forces for change (Wharf, 1992).

The British Columbia Association for Community Living (BCACL) discovered with the closure of Tranquille what many other sectors were learning. Government was not interested in joint planning in the closure process (Lord & Hearn, 1987). BCACL was not going to be able to directly influence government planning and policy in downsizing. In 1984 Tranquille moved approximately 260 residents to community based services and transferred the remaining 55 individuals, labeled as 'extended care eligible' or 'medically fragile' to Glendale Lodge in Victoria. It was decided that support in the community was inadequate at that time to ensure safety of these individuals. Transfer of these residents to Glendale instead of to community was extremely frustrating for BCACL. It must have seemed to them that government was changing its mind. In the fall of 1984, it appeared these 55 people would be institutionalized for a long time. According

to Lord and Hearn (1987), in order to communicate to government their continuing interest in deinstutionalization, BCACL organized volunteers to visit these 55 individuals at Glendale on a regular basis, and their families were encouraged to stay in touch. BCACL lobbied government on several occasions and also filed a complaint with the human rights branch on charges of discrimination. With their extensive contacts in government, BCACL was eventually able to gain access to the Premier's office which in turn facilitated meetings with Ministry of Health (MOH) officials. The Deputy Minister of Health was a key player in this process. There was no question that public attention on the issue had created a climate to which MOH had to respond. According to Lord and Hearn (1987), MOH officials said they had never experienced such strong and extended pressure. This led to the MOH philosophy statement favoring community living and family support for all people regardless of the degree of disability and the decision to close Glendale Lodge (Lord and Hearn, 1987). There was no question that government had to go forward with their plans for deinstitutionalization. They also had to create a community structure which would allow this to happen.

Organizational Structure for Deinstitutionalization and Community Living

In response to pressure from BCACL to move the 55 adults who had been transferred from Tranquille to Glendale Lodge to the community, Ministry of Health formed Services to the Handicapped Branch in 1986. This branch was eventually re-named Services for Community Living (SCL). It was created to provide services for adults with mental and physical disabilities who required 'extended care' and whose health status was considered medically fragile.

Besides the Ministry of Health, the Ministry of Social Services was also involved in delivering community based services to adults with mental disabilities. Up until a reorganization in 1988, coordination of services for adults with mental disabilities was provided by all social workers in the Ministry of Social Services. With the community population of adults with mental disabilities growing it was decided that the needs of this group warranted specialized services. A Ministry of Social Services reorganization resulted in the creation of "Services To People With Mental Handicaps" (SPMH) offices. A new role was created for social workers to provide service exclusively in this area. With adults, work is directed by a set of Service Principles and centers on a Personal Service Planning (PSP) process. Both the Service Principles and PSP are important to this thesis and will be discussed extensively in a later chapter.

Two issues in providing services for people with mental disabilities in this region became apparent. Problems with discharge planning or the downsizing process; and two separate ministries providing services to the same population of people with mental disabilities needed to be addressed.

Discharge Planning

It was a well known fact that the downsizing process used at Tranquille had many flaws. Problems with this process were reported in research by Lord & Hearn (1987). Families in the region of my study had already experienced difficulties with discharge planning for those adults who had previously been deinstitutionalized from Glendale. Consequently these families and other advocates were feeling uneasy about further deinstitutionalization of those who remained in institutions. This was because individuals who had yet to be moved to community from institutions had severe mental and physical disabilities and

required higher levels of support than adults previously deinstitutionalized. There were two concerns. First, if community resources for support were not available for people with severe disabilities then their lives may be at risk. Second, if community living experiences were not successful, then these individuals could face possible re-institutionalization.

Government has funded family support groups such as "Western Family to Family" and "FACTS" (the Glendale Lodge family) for many years. It is important to note that these groups monitored the process and progress of deinstitutionalization and expressed concerns. Awareness of these concerns by government and the administration of institutions led to an extensive community consultation process called "Planning For The Future".

Planning For The Future

During the winter of 1990-1991 the Ministries of Health and Social Services embarked on an extensive community consultation process based on the publication "Planning for the Future" (the "blue book"). This publication was a proposal for services for people with mental disabilities. The ministries distributed approximately 5,000 copies of this publication, which outlined existing and proposed support service networks which would form the foundation of a comprehensive community-based service system. This document was developed by an Assistant Deputy Minister of the Ministry of Social Services and a small group of civil servants. It came about as I mentioned earlier because of pressure from administration and families of residents in Glendale Lodge and the British Columbia Association For Community Living (BCACL) to formalize a plan for community services. This plan was also to include looking at realignment of services between the Ministry of Health and the Ministry of Social Services. It

was becoming apparent to both the Ministry of Health and Ministry of Social Services how complex the downsizing of institutions and the development of community resources would be. To address this complexity, Cabinet directed that a joint Ministry of Health and Ministry of Social Services management structure be created, called the "Transition Steering Committee" (TSC). The mandate of this committee was to manage:

1. The gradual reduction and eventual closure of B.C.'s two residential institutions for people with mental handicaps - Woodlands and Glendale Lodge;

2. The development of a comprehensive network of community-based services for people with mental handicaps to replace the services previously provided by the two institutions; and

3. The realignment of responsibility for services provided to people with mental handicaps by the Ministries of Health and Social Services.
(Planning for the Future, 1994, Bulletin #8).

The focus of my research is the second point of this mandate, community based services. Membership on the Transition Steering Committee included representation from: Ministry of Health; Ministry of Social Services; British Columbia Mental Health Society; Institutional (Glendale and Woodlands); Community Consultants (BCACL, Western Family to Family); and staff support members. This committee was given responsibility for the orderly downsizing of institutions and simultaneously implementing a network of community-based services.

To accomplish this mandate, the Transition Steering Committee used a standard bureaucratic approach and created 8 sub-project committees which had fairly wide representation. These sub-projects were:

1. Professional Support Services

2. Dental Services
3. Mental Health Services
4. Problem Solving, Conflict Resolution and Review Mechanisms
5. Challenging Behaviors
6. Health Care Access
7. Training Project Team
8. Monitoring Project Team

In addition to the Transition Steering Committee, the Assistant Deputy Ministers Committee continued to be responsible for other related activities around the deinstitutionalization policy. This underlines the apparent interest at a fairly high level of government for implementation of this policy.

This thesis takes up work that falls out of the Professional Support Services sub-project from which there was development of Health Services for Community Living (HSCL). This program as I said previously was implemented to provide professional nursing and rehabilitation supports to adults with mental disabilities who were supported by Ministry of Social Services. Most of these adults live in group homes. This is where I personally became involved for the first time with community services for people with mental disabilities. In the beginning it was confusing for us in the local health services to fully understand the role nurses were to play. It was clear from the outset that families of residents in group homes wanted some form of regular monitoring for their family members to ensure safety. However, it was also clear that managers in group homes did not want regular monitoring. To do so was in their minds to re-create a 'medical model' that they hoped had been left behind in institutions.

Families and advocates as was previously noted, were not happy with the process of discharge planning from institutions. There were concerns about the development of appropriate community resources to replace those that had been

available in institutions. It was important for government to address these concerns in order for deinstitutionalization policy to be successful. To do this, government had formed a Provincial Advisory Committee (PAC) in 1988.

Provincial Advisory Committee

According to MSS bulletins, since 1988 the Provincial Advisory Committee (PAC) has made recommendations on a variety of issues, including models of care, health support services, standards and monitoring, training, family and community consultation. PAC membership includes representatives from both the Ministry of Health and Ministry of Social Services, families, advocacy groups and consumers. Important to this thesis is the development by PAC of 11 Service Principles designed to form the foundation of services for people with mental disabilities provided by Ministry of Social Services. These 'Service Principles' were adopted by the Transition Steering Committee in 1992 as a guide for realignment of the two ministries. They were ratified by Cabinet and formally written into ministry policy. The implication of these Service Principles will be discussed in more detail in my data analysis chapters. Formation of the Transition Steering Committee and Provincial Advisory Committee with representation from consumers, families, and advocates can be seen as governments way to elicit support for their policy.

Two Ministries

In addition to difficulties with discharge planning, there was the issue of two separate ministries doing the same work. The Ministry of Health and the Ministry of Social Services both provided services to individuals with mental disabilities. This resulted in a very complex and at times confusing deinstitutionalization process and provision of community services. The mandate

of the "Transition Steering Committee" included realignment of services provided by these two ministries. For the purpose of this thesis it is enough to say that by the end of 1997, realignment has progressed to the point that Services to Persons With Mental Handicaps (SPMH) and Services For Community Living (SCL) have been consolidated in the Ministry of Social Services (now called Ministry of Children and Families). Movement toward realignment had been realized with the adoption of the same "Service Principles" in 1994 by both SPMH and SCL.

Now that the complexity of deinstitutionalization and realignment has been explored, how support services for people with mental disabilities are structured needs to be uncovered. In this thesis I have used policies, documentation and recollections from staff of the Ministry of Social Services, "Services to People with Mental Handicaps" (SPMH) Office. Although the ministry has changed its name, policy manuals retain the title Ministry of Social Services (MSS). That is why for consistency in this thesis I refer to the government structure as Ministry of Social Services rather than the new name of Ministry of Children and Families.

Ministry of Social Services (MSS) as an Organization

The Ministry of Social Services is organized as a corporate hierarchy. Services For People With Mental Handicaps (SPMH) Office employs social workers who report to supervisors, who report to managers who report to executive directors who report to an Assistant Deputy Minister who reports to the Minister of Social Services.

The MSS Community Support Services Policy Manual outlines the Community Support Services programs that are available. These services are in

three program categories: Services for Adults with Mental Handicaps; Services with Children with Special Needs; and Community Services. Services For Adults With Mental Handicaps is the one that is important to this study and is discussed in further detail.

Services For Adults With Mental Handicaps

MSS has the following "Service Objectives" for adults with mental handicaps:

> "The Ministry of Social Services offers support to adults with mental handicaps. Under the mandate of the GAIN Act, the ministry provides a range of services and supports to adults to help them achieve their maximum independence and participate as members of their community. Services are centered on the individual's needs and focus on ensuring and enhancing the quality of the persons life.

The ministry's service for adults with mental handicaps are designed to meet the following objectives:

> To assist people to live as independently as possible in the community;
> To involve the community in planning and delivery of services for adults with mental handicaps;
> To increase public support for community integration of people with mental handicaps;
> To increase families participation in planning for people with mental handicaps;
> To improve inter-ministry co-ordination in providing services for adults with mental handicaps;
> To manage service contracts to provide a greater sense of partnership by service providers;
> To continue developing networks of community supports for individuals with a mental handicap;
> To continue planning for residents of institutions to move to community settings.
>
> (Community Support Services Policy Manual, 1992, 2. 1. p. 1)

According to Ministry of Social Services, adults with mental disabilities have the same human and legal rights as all adults. In keeping with the ministry's

principle of integration, these adults are entitled to receiving services they require from generic programs in the community. Therefore, other ministries have a significant role to play in meeting needs of people with mental disabilities. For instance, the Ministry of Health provides such services such as nursing, therapy, hospital care, mental health and dental services. The Ministry of Attorney General becomes involved when people with mental disabilities are in conflict with the law and Ministry of Municipal Affairs, Recreation and Housing assists when housing issues are being considered.

I began to see from the Service Objectives that MSS is building the philosophy of normalization into its standards. This continues to be reflected in the following descriptions of services for adults with mental disabilities.

Description Of Services

Underlying the standards statement in the policy is a "philosophy of quality care" which outlines principles which form the basis of recent changes in approaches to caring for persons with mental disabilities. These changes focus on these persons commonality with, rather than their differences from society as a whole. Services are no longer seen solely as provision of care to an individual by a caregiver; they now entail provision of support to minimize the disability of that person to allow him or her, as much as possible, to make choices, solve problems, take responsibility and become self-managing (Policy 2.2.2., p. 2). Ministry services operate under the following philosophy:

> Philosophy of Quality Care:
>
> Respect for the uniqueness, dignity and worth of each individual;
> Recognition of each individual's need for a sense of self-respect and self-determination;

> Recognition of each individual's need for personal happiness and satisfaction;
> Recognition of each individual's need for a meaningful life;
> Recognition of each individual's need for meaningful communication and social interaction;
> Promotion of the individual's maximum personal and functional independence;
> Recognition of the importance of the individual's family as a resource in planning and support;
> Promotion of the individual's participation in decisions which affect him or her. (Policy 2.2.2.p. 2).

The ministry is building community services away from the concept of institutionalization. In order to ensure that individuals with mental disabilities can live in community, the Ministry of Social Services recognizes that certain needs must be met. Residential Services, Day Services and Supports for Service Providers and Families are funded and provided to individuals with mental disabilities by MSS. These services are now discussed in more detail.

1. Residential Services

According to the MSS Community Support Services policy manual, residential services operate under the philosophy that adults with mental disabilities must have the same rights and opportunities to live in a home of their own in community in the same way that all adults do. These adults should also have choices about style of community housing and people they live with. To receive residential services individuals are needs-tested using the GAIN Application, S 80, to determine if they should pay a user fee for residential care or if they are eligible for comforts, clothing and transportation allowances.

(MSS Community Support Services Policy Manual 2. 3. 1, p. 2)

Ministry of Social Services (MSS) staff work with societies and agencies in all provincial regions to develop new homes in the community. They are often referred to as residential resources. Residences may be either society-operated (operated by nonprofit societies) or privately operated (operated by private agencies, individuals, partnerships or limited companies). The privately operated homes are also referred to as for-profit homes as opposed to non-profit homes usually run by societies. MSS contracts for the provision of housing for individuals with mental disabilities. Payments vary depending on the level of support individuals require. All residential service providers must follow written ministry standards, "Standards for Residential Services" as per MSS Community Support Services Policy Manual, Part 2, Section 2, Subsection 2.

Residential options include semi-independent living, respite and relief services and intensive adult care as well as community residences such as group homes which are the focus of this study. Community residences vary in size from small family homes to larger residential facilities and provide care and support for adults with mental disabilities. Currently there are approximately 190 residential resources serving approximately 450 individuals with mental disabilities in the region of this study with a budget of around 24 million dollars. The majority of residents from downsizing of institutions in this region were moved to staffed group homes which are home to 4 residents. A group home with 3 or more residents is subject to provincial licensing guidelines. How do these group homes get established in the first place? In the next section I review the contracting process used to establish a group home.

The Contracting Process for Residential Resources

There is a process for establishing group homes in the community. Under the GAIN Act, MSS is given statutory authority to purchase services on behalf of individuals, including residential services for people with mental disabilities. Ministry policies and procedures for contracting are detailed in the "Guide To Contract Management" which provides information on managing all government contracts (not just residential) from planning to evaluation.

A Services to People With Mental Handicaps (SPMH) supervisor reviewed with me the process of contracting for a group home. First, it is established in the Personal Service Planning (PSP) that an individual requires a group home. From that point there are two options to getting the contracting process started. One is to advertise in the newspaper requesting proposals for a contract and at the same time advertise a "bidders meeting". The second option is to select about seven known and proven service providers and request proposals from them. Once proposals are received the SPMH supervisor (if responsibility for contracting has been delegated from the Area Manager) and two social workers (who will be working with individuals requiring this home) review these proposals against rating guides in the Contract Management Manual. A short list is drawn up of service providers who meet the necessary requirements. The service providers on this short list are then expected to do a presentation for the family of the individual needing the home. Following these presentations, family make the final selection of the service provider. If there is no family involvement, SPMH Supervisor and Social Workers make the decision.

The budget for staffed group homes is negotiated between Service Providers and SPMH based on the needs of residents. Funding for residential resource (group home) contracts is the responsibility of MSS.

Once contracts are in place, a monitoring process follows. A supervisor of SPMH says that monitoring is expected to come from a variety of sources:

1. The Provincial Review Team (established in 1992) reviews a new home within the first year of operation, and then every 2-3 years following. The work of this team is viewed as developmental in assisting homes to meet provincial standards. The standards or guiding principles for quality service are presented in the following 14 domains:

safety and security, individual care, personal support, individual rights, individual planning, home environment, policy and procedures, staffing , supervision, staff training, activities and programs, use of community resources, problem resolution, and transition to home (MSS Community Supports PolicyManual, 2.2.2., p. 4-13).

2. The Capital Regional District's, Licensing Division has the mandate in statute to make routine checks and investigate complaints in group homes that have 3 or more residents.
3. Family and friends of residents in the group homes.
4. Social workers, nurses, therapists etc.

The MSS stance with regard to "Standards for Residential Services for Persons with Mental Handicaps" is that as ministry staff and residential contractors fulfill their obligation by ensuring adherence to these standards, quality of life for individuals with mental disabilities will be enhanced. According to MSS, documenting the application of uniform standards can provide assurance

to caregivers, the public, friends and families of people with mental disabilities that care provided is appropriate and meets acceptable standards of quality in each residential facility. It seems that adherence to standards equals quality of life according to MSS. Once a contract has been established for a group home it is the contracted Service Provider who has responsibility for ensuring standards are met.

Group Home Structure

Service Provider

Service Provider refers to different structural configurations. It may refer to: one person who has responsibility for one or more homes; or a profit agency which is set up in a corporate hierarchy and has responsibility for a number of homes; or a non-profit agency which too may have a hierarchical structure and be responsible for more than one home. To ensure that group homes are well run and standards are met, Service Providers hire managers who are given responsibility for day to day management of group homes. There are group homes in Victoria where the Service Provider is also the Manager, but for most homes managers' report to Service Providers, who negotiated the contract with ministry.

Manager

Of key importance to group homes are managers who are responsible for day to day operation of these home. Depending on the service provider agency involved, the manager can also be referred to as 'supervisor' or 'person in charge' (PIC). Managers come to their positions with a variety of backgrounds. Some have post graduate degrees or diplomas while others have no formal post

secondary education but have worked in group homes as community support workers. Although the philosophy of community living is away from the 'medical model', there are a few homes where registered nurses or registered psychiatric nurses have been hired as managers due to the fragile medical status of residents in these homes.

The manager, responsible for the day to day functioning of the home has the following responsibilities:

* Managing the day to day operation of the home
* Assisting in the hiring of staff
* Orienting and training of staff, performance appraisals
* Monitoring the budget, payroll, petty cash, residents bank accounts
* Ensuring upkeep of the house
* Working as a line staff member with the residents in the home
* Submitting reports on the residents to MSS
* Participating in Personal Service Planning (PSP) meetings with MSS
* Liaising with MSS social workers
* Liaising with family and advocates
* Liaising with health care professionals and professional supports
* Meeting regularly with the Service Provider Agency
* Developing policies and procedures

Staffing Group Homes

Staff hired to work in group homes are called Community Support Workers (CSW). They can be graduates of a community college 10 month program, have on the job experience or have no training or experience. Previously they might have been trained in an apprentice-like 3 month program at

Glendale Lodge but that program is no longer available. Some workers are unionized, some are not, depending on the group home.

2. Day Services

The second community program to be discussed is 'day service'. Besides looking after housing and personal care, the ministry provides funding for societies, agencies, or private individuals to operate programs that offer training and support for adults with mental disabilities to assist them to become as independent as possible. Training and support programs provide opportunities for people to achieve their personal goals and participate in community life. Contracts are established by MSS to provide programs that residents in group homes can participate. Often the day programs are likened to going to work, as a normal part of a day for most people. There are individual and group programs available through these contracts.

3. Supports for Service Providers and Families -

The third community program offers professional support services which are available to service providers, families and ministry staff, to help them provide effective community living supports for individuals with mental disabilities. The ministry contracts for professional support services to assist with such things as personal planning, inservice training for service providers, liaison with vocational services, monitoring and evaluation of programs, or assessment of referred individuals. An example would be augmentative communication or psychological assessments.

In this chapter I have provided the context for my study and have started to show how as a result of deinstitutionalization, normalization philosophy is

being embedded into ministry policies and descriptions of services. Residential services are crucial to the success of community living for adults with mental disabilities. From the point of view of the ministry, application and documentation of residential standards is key to these adults having a quality (normal) life. In the next chapter I peel back another layer of MSS systems to reveal the processes that are meant to 'normalize' life for adults with mental disabilities in group homes.

Chapter Five

The Discursive Organization of Group Home Policy and Practice in British Columbia

In the previous chapter I showed how concepts of normalization are drawn into ministry standards and policies and how 'normalization' is embedded in programs, at least in 'theory'. This chapter contains data on Ministry of Social Services (MSS) systems that 'normalize' the lives of people with mental disabilities and the work processes of group home managers that accomplish this. I elaborate on Smith's (1990) concept of social relations as outlined in the literature review, as well as her concept of "ideological practices" to show how this happens. I have drawn on notes from my work with Health Services for Community Living (HSCL) and publications and policy manuals of the Ministry of Social Services (MSS). I analyze the 'discursive' organization of Services to People with Mental Handicaps (SPMH). I argue that normalization in the community care of people with mental disabilities becomes accomplished in and as text-based management practices. This is an ideological construction of normalization.

Stories of group home managers' work led me to an analysis of ministry documents. The reflexive analysis of ministry documents led to my understanding of the discursive organization and ideological construction of normalization. By doing this, managers' stories which are detailed in Chapter Six began to make sense. These stories were the point of entry that enabled me to explicate the social relations in managers' work. In the last section of this chapter a story about 'the swing' and in the next chapter, stories about activities,

equipment, and neighborhoods show the disjuncture in the lives of residents, managers, and community support workers.

Discourse As Policy/Practice

The principle of normalization was adopted as a primary concept for Associations for Community Living that have been advocating for people with mental and physical disabilities for many years. This knowledge, and the ideas about the principle of normalization found in Chapter Two, I suspect contributed to government policy and program development using normalization philosophy for community living. The Ministry of Social Services (MSS), by adopting this principle both implicitly and explicitly in the policies and guidelines developed in the MSS Community Support Services Policy Manual, appears to be responding to demands from advocates of the community living movement. These advocates are wanting people with mental disabilities to have equitable treatment and the same living circumstances as anyone else in society. Having developed policy and programs, the government was forced to implement them successfully.

Implementation of community living in group homes is governed by standards, guiding principles and legislation such as: the MSS Community Support Policy Manual, Standards for Residential Services for People with Mental Handicaps; the Community Care Facilities Act; Adult Care Regulations, B.C. Reg. 536/80; Pharmacy Act; GAIN Act; and the Service Principles. Policies and procedures are a way of managing what government will and won't do for people with mental disabilities, and establishing the responsibilities of different parties. I will show how one discourse is conceptually linked to others providing the coordination and articulation of institutional activities. In other words, a strategy for managing implementation of policy.

Service Principles

The Service Principles are the core values used in the development of community supports and services for people with mental disabilities. As was mentioned in the previous chapter, these principles were developed by the Provincial Advisory Committee (PAC). They guide the orientation of new government employees and all those associated with community living services. In my own experience, when meeting with MSS management staff and social workers, these staff draw attention to the importance of the Service Principles, particularly for those of us new to working with individuals who have a mental disability. According to the MSS Community Supports Policy Manual (part 2, section 1) the Service Principles are needed for two primary reasons:

1. to support and empower all people with mental handicaps to make their own decisions; and
2. to make sure that people who are supporting them in making their own decisions are working from the same foundation.

Although supporting and empowering people is very much part of the rhetoric of MSS community services, there is also an implicit reference to ensuring standardization and control of the process. Policy indicates that the Service Principles entrench the right of people with mental disabilities to be treated like anyone else in the community, with respect and regard for human dignity. It is clear from the reasons noted above that service providers must have the same collective understanding of how service should be delivered.

According to the MSS Community Supports Policy Manual, the Service Principles are as follows:

1. Respect for the Individual

   Services will respect the human rights and dignity of the individual, will be developed to meet the individual's needs, and will seek to support the uniqueness, strengths and qualities of each person.

2. Self Determination

   Individuals have the right to control and take responsibility for their own lives. Services will enhance opportunities for people to act on their own behalf wherever possible and, at all times, to participate in decisions that affect them.

3. Personal Service Planning

   Services for each person will be developed through an individualized planning process. Wherever possible, the individual will be supported and encouraged to participate fully. The process will encourage and support the person's unique characteristics, strengths, and needs, and will be reviewed on a regular basis.

4. Family Involvement

   An individual's family (natural or alternate) will be a key resource and support in all planning services. Services will support family relationships, help families to maintain or develop their involvement with the individual, and provide for participation of family support agencies for those individuals who do not have active family support.

5. Maximizing Independence and Growth

All people have the potential to grow and to develop physically, intellectually and emotionally. Services will provide people with support and opportunities to achieve this and reach their maximum level of self-reliance.

6. Maximizing Environmental Choices

   Services will be provided in an environment that allows people the greatest degree of freedom possible, while at the same time providing for their safety and security.

7. Community Inclusion

   Services will support the inclusion and integration of people with mental handicaps into the mainstream of community living. Wherever possible, people will have access to the same lifestyles and appropriate services that are available to non-handicapped people in the community.

8. Quality of Life

   All services for people with mental handicaps will focus on ensuring and enhancing their quality of life. This is based on the recognition of each individual's need for personal satisfaction and meaningful social interaction in their day to day living. A person's quality of life can be characterized by the following benefits:

   -health and safety,

   -personal power and choice,

   -personal value and positive recognition by self and others,

   -a range of experience which help the person participate in community life

   -good relationships with friends and relatives,

-ability to manage daily activities and pursue personal goals.

9. Generic Services

Services will be based on the use of generic services which are available to all citizens. These will be adapted as necessary to meet the needs of people with mental handicaps. Only if universal services cannot be adapted, will specialized services be developed by generic service systems. This will assist the integration of people into the community.

10. Community Partnerships

Services will be developed and delivered in partnership with service providers and community professionals, and the community service network, based on a cost-effective use of available funds. The partnership approach will provide opportunities for creative ways to support people and meet their needs in the community.

11. Conflict Resolution

Services will operate in an open manner to encourage communication and joint problem-solving between individuals, their families, ministry staff and service providers. If problems arise, a review process will be used to resolve potential conflicts

(Community Support Services Policy Manual, 2, 1, p. 1-3)

The Service Principles set up normalization as an ideological frame for community living in group homes. Wolfensberger's (1972) concepts of normalization as were discussed in chapter two can be found in the Service Principles. George Smith (1995) suggests "the ability to embed the description of

people's activities in a wider set of social relations depends ... on an important ontological property of social courses of action - their recursivity" (p. 32). This recursivity can be found in the following examples of Wolfensberger's corollaries in relation to the Service Principles (see page 11 of this document for the list of corollaries). Wolfensberger's all encompassing corollary number one (regarding cultural normativeness) relates to all the Service Principles but in particular to principles #3, #6 and #8 which are personal service planning, maximizing environmental choice, and quality of life. Corollary number two (regarding developmental expectations) can clearly be seen in principle #5, maximizing independence and growth. An extension of principles #7, community inclusion, is related to corollaries three and four, (regarding integration and continuity of activities and services) and the final corollaries of five and six (regarding separation and smallness) are implicated in the principles #2, self determination, and #3, personal service planning. This begins an extended course of document-based action in which normalization is accomplished as textual/discursive as opposed to 'actual' (Smith, 1990) experience. This discursive action creates a disjuncture which I take up as I analyze my data about the troubles that managers experience in this chapter and the next. Service Principles give direction as to how services for adults with mental disabilities are to be delivered. They express what MSS, family and advocates want for these adults. Analytically speaking, the principles may look appropriate on paper, but no matter how well intentioned, it is their interpretation and implementation in the community which determines how beneficial they are to adults with mental disabilities. My research addresses this dichotomy in the next chapter. In large part, implementation becomes the work of managers in group homes. The Service Principles are recursively embedded in their work of constructing 'normalization'. For instance,

"Standards for Residential Services" are the key standards applied to group homes. The introduction to the standards says:

> "The purpose of this policy is to reflect the ministry's commitment to the provision of quality services to individuals with mental handicaps by stating the standards for residential care that are to be adhered to. As ministry staff and residential contractors fulfill their obligations to ensure adherence to these standards, the quality of life for individuals with mental handicaps will be enhanced" (MSS Community Support Services Manual, Standards for Residential Services, 2.2.2 page 1).

The intent of the ministry is clear. The competent use of standards assumes a satisfactory outcome. Adherence to the criteria of residential standards means there will be a quality (normal) life. In questioning this assumption, I look further into the discourse of normalization.

According to Griffith (1995), discourse refers to an organization of relations among people participating in a conversation mediated by written, filmed/videoed, and printed materials. The term is adapted from Michel Foucault "The Archeology of Knowledge (1972). As Griffith uses it, "the term does not just refer to the "texts" of this conversation and their production alone, but to the ways in which people organize their activities in relation to them" (p.121). In the previous chapter I began to show that there are printed materials related to a normalization discourse. I continue to explore this discourse by explicating the work processes of those who are responsible for programs for community living. My goal is to show how this work, following standards, rules and regulations is expected to normalize the lives of people with disabilities. I want to know what actually happens. The Service Principles are part of a discourse on normalization that ties together people with mental disabilities, activists, families, the state and, as I will show, ministry staff accomplishing the work of the state.

I argue in this thesis that normalization is an ideological construct, which does not necessarily result in a life of quality for adults with disabilities. In order to understand ideology I look to Smith (1990) whose views had their beginnings with the ideas of Marx. She notes that "ideas and concepts as such are not ideological. They are ideological by virtue of being distinctive methods of reasoning and interpreting society" (p.36). She goes on to say that "ideology can be viewed as a procedure for sorting out and arranging conceptually the living actual world of people so that it can be seen to be as we already know it ideologically" (Smith, 1990 p.43). To relate Smith's ideas to this study I am interested in the processes managers use to accomplish their work and who and what these processes intersect with. Where are the linkages? To begin to answer these questions I reviewed managers' involvement with the MSS Personal Service Planning (PSP).

Making A Client

In this section I discuss work processes that are connected to Personal Service Planning (PSP). I argue that the PSP is an ideological practice that enters into the production and interpretation of factual accounts of the lives of adults with mental disabilities living in group homes. I contend that what actually happens in the lives of residents and managers in group homes is a social and ideological construction of normalization. This is not necessarily the same thing as residents having a normal (quality) or even satisfactory life.

During my interviews, managers referred to a work process that involved a PSP. I knew superficially about the PSP from my work with HSCL and knew it was seen to be the individual planning process for each resident in group homes. On further investigation I found that the PSP is the core document and procedure

in planning services for an individual with mental disabilities who is receiving support from the MSS. The Ministry of Social Services "Personal Service Planning" (PSP) Policy has the following objectives:

1. To standardize the ministry's planning for services for adults with mental handicaps while allowing for individual variation.
2. To individualize the planning process to accommodate the unique characteristics; strengths, and needs of each individual receiving services.
3. To ensure that appropriate and effective services for individuals with a mental handicap are provided in an efficient and timely manner.
4. To ensure the participation in the planning process of each individual receiving services.
5. To develop jointly with each individual a plan of action that addresses current and future service requirements, and supports the individual as independently as possible in the community.

(Community Support Services Manual, Part 2, Section 2, Subsection 1).

I learned that the PSP has five distinct stages of development: intake, assessment, development, implementation and review. It is important to note that the Ministry of Social Services (MSS) social workers, as case managers, play a key role in this process. The MSS social worker works with adults with disabilities and their families, with service providers, managers, professionals and the community to develop, monitor, and implement these individual care plans. In the intake and assessment stages, the social worker, in consultation with the MSS district supervisor, determines the individual's eligibility for ministry services and assesses the person's needs based on information from many sources. It is at this point that the person with disabilities, if they are eligible for services, becomes a 'client' of the social services system. Analytically speaking, I contend that this initiates the view of the group home resident as an object, as a problem to be solved, and work to be done, with normalization being the goal. My critique,

which appears in this chapter and the next, shows how the PSP produces an ideological account which organizes the person's life in relation to the ideological version of normalization, but may miss entirely what an individual's normal or everyday requirements might be. I will also attempt to explain how this happens in spite of the best intentions of all involved.

In the development stage of the PSP, the social worker brings together a planning team unique to the individual. This team includes: the manager of the group home, the individual with a mental disability, the individual's family member or advocate, and representatives of other ministries or agencies such as the HSCL nurse or therapist. This team is responsible for developing the plan which outlines the resident's goals, (based on individual needs and strengths) and establishing reasonable time lines for implementation.

The roles of participants and the documentation required of the PSP process are defined within the Ministry's hierarchical structure of accountability. The district supervisor reviews and authorizes each of the five stages of implementation. The MSS area manager (or delegate) negotiates and authorizes contracts for services, develops resources, and consults with the district supervisor on critical incidents and exceptional cases. As well, for each stage of implementation specific forms must be completed. I see this planning process as requiring significant documentation and supervision. The PSP process is part of a hierarchical bureaucracy similar to bureaucracies in hospitals and community health organizations. The documentary process guarantees that desired outcomes are reached.

A formal ministry review of the PSP two years after it was implemented ("Personal Service Planning Process Phase ll - Review", 1994) brings out several points which allow us to see bureaucratic control in action. The review took place over a period of 14 months involving meetings of committee members from each of the provincial MSS regions. Administrative support workers, case and resource social workers, district supervisors and an area manager attended the meetings. Additional support was provided through the Staff Training Division, Community Support Services, Procedural Services, Research Evaluation and Statistics, and System Services Division. I note this additional support to highlight the extensive amount of planning for accountability that seemed to be required for the review process. An integral part of this review involved the use of information from an earlier evaluation of the PSP process reported in "An Evaluation of the Personal Service Planning for Adults with a Mental Handicap: Research, Evaluation and Statistics Branch, MSS, December 1992. In fact, I would suggest that the number of MSS resources reviewing the PSP process gives some indication of the importance of this process to government.

The PSP process can be seen as good policy and program development. I also see it as government's way of reconceptualizing the community's view of people with mental disabilities away from the concept of institutionalization. Adults with severe mental disabilities had always been treated as 'custodial care' recipients; now the ministry has worked out a new way of thinking. I suggest that constructing the ideology of normalization around the PSP, with its emphasis on individual planning and choice, was a way for government to manage their deinstitutionalized clients successfully in the community. The policy makers took up the concept of normalization in its practices to satisfy parents and advocacy groups who were a) critical of ministry discharge planning

and b) looking for a process which would ensure that people with mental and physical disabilities were safe and had their needs met in the community.

A text-based accountability system is a taken for granted method of ensuring compliance with policy in bureaucracies. The implication is, that if a standardized process for individual planning satisfies families and advocates, community living is working. As can be seen in the following features from the review of the PSP process, I believe families/community advocacy groups had some influence in government reinforcement of normalization principles.

The MSS review of the PSP process resulted in continued bureaucratizing of community living for adults with mental disabilities in group homes. It brought further attention to the need for standardization and documentation of the group home resident's situation - a method by which the ministry could ensure compliance with policy. Features of the revised process which are relevant to this study are: that the PSP will:

- Stress autonomy of practice and regional approaches while maintaining provincial consistency,
- Stress flexibility to allow for individually focused preferences and circumstances while promoting the consistent application of the "Service Principles" provincially,
- Introduce enhancements to system support and administrative procedures which will: streamline the process, reduce the paper work, utilize current technological advances,
- Recognize the need for staff training opportunities for district office staff, Social Workers, and District Supervisors and further enhance the role of the PSP in Services to People with Mental Handicaps (SPMH) practice,
- Emphasize the "Service Principles" as the foundation for decision making with the cooperative development of strategies to guide practice issues,
- Allow for timely and efficient gathering of information that will assist Ministry staff at all levels

(Personal Service Planning Process Phase II - Review document, 1994, p.3).

Besides addressing normalization and the Service Principles, the review offered an opportunity to stress management principles for group home work. The above exerpt from the review highlights the ministry's need for a process that is consistent; one that will support administrative procedures, which will utilize current technological advances for timely and efficient gathering of information and will assist the ministry at all levels. Policy makers were convinced that if families and advocates see there is an individualized process of planning and accountability, they can be reassured that residents in group homes are having their individual needs met in a way that addresses normalization. I insist that this was an assumption and needs to be checked against what actually happens.

Efficiency and accountability have become the hallmark of good management. The PSP provides a systematic accountability for what happens in group homes and provides, as Jackson (1995) says "a framework of institutional relations in which the problem of accountability can be addressed rationally and systematically" (p.177). I argue that the policy drifts away from parents/advocates concerns to 'efficiency and management'. To gain insight I look specifically at the PSP process in the work of the manager.

Once the PSP planning meeting for residents in group homes is complete, the MSS social worker submits the information in PSP format outlining agreed upon goals and objectives for the residents. These goals and objectives are related to the following categories under the heading of Personal Information: Home; Social/Community Networks; Health; Education/Work; and Community

Involvement. Information is to be recorded using the following headings: Strengths and Needs/Goals; What Is To Be Done; Who Will Do It; When Will It Be Done. In reviewing some completed PSP forms, I note that the information in the Personal Information section is written in narrative form. Goals are written as statements for example: "Increase (resident's name) interaction with community". There were no details of how this is to be accomplished. It is not expected that the PSP be a detailed implementation plan. A copy of the completed PSP is distributed by the social worker to the group home manager. It then becomes the manager's responsibility to implement the goals documented in the PSP. As part of their work process, the manager produces a "Quarterly Report" for the ministry which are summary reports on progress toward goals in the PSP. The discursive action must go forward, even in absence of complete success in everyday implementation.

Or as I will show in the next chapter, the discursive and everyday implementation separate. To further explicate this discursive action I take a closer look at the Quarterly Report.

Quarterly Report

The "Quarterly Report" is an essential part of the construction of normalization. To my mind, discursive and ideological. Here I see normalization and efficiency interests collide. Recommendations from the review of the PSP process included adding to the Community Support Services Policy Manual the following:

> "The contract schedules should emphasize the role of service providers in the PSP process. Service providers will develop a person centered plan that addresses PSP goals and submit summary reports on the progress

> towards the PSP goals on a mutually agreed upon timeline" (Personal Service Planning Process Phase II - Review, 1994, p.7).

Although this was not written in the PSP process prior to the review, the submission of summary reports known as Quarterly Reports by the service provider (manager in group homes) had become established practice and subsequently part of the review process.

The Quarterly Report is submitted every three months by managers in group homes to their MSS social worker. The social worker uses these reports as part of the personal file of the group home resident, and as information to include in the annual PSP review. Data is collected in the Quarterly Report by ministry required categories. When asked about the information required for the report, one manager said:

> "These (headings for data) are the ones that we have come up with as a group of supervisors with input from the ministry as well, to what they need to know. They (the ministry) use it to justify people actually being in these programs and to see if there are any problem areas that we need to work on or how things are going" (Fieldnotes, March, 1997).

While observing in a group home I noted:

> The headings that this group home worked with are: "community involvement; community skills; transportation; leisure and recreation; social networks; social and family contacts and communication; health; medication changes; general mobility; life skills; personal hygiene; home management skill; money/management/banking; work/education; paid employment; volunteer/work skills; interests; goals attained; changes; individual needs; individual wishes; other" (Fieldnotes, March, 1997).

The Quarterly Report is designed to ensure that progress is being made toward the goals that have been established in the PSP. The headings for the data correspond to the Residential Standards criteria used for the Provincial

Review Team evaluation which was discussed in chapter four. In analytic terms, the Quarterly Report categories are recursive expressions of the standards, which I suggested earlier reflect normalization principles. As the manager stated above, the Quarterly Report is recognized by managers as a tool for group home accountability to the ministry. The Quarterly Report and PSP actualize (normalization) policy ideas into text. The text moves through bureaucracy, authorizing work processes. Within group homes themselves, the reporting function necessitates more record keeping. A documentary process is set up for group home workers, (Community Support Workers) to record daily occurrences in the lives of group home residents. This information can then be used as a resource for recording in the Quarterly Report. It is my contention that these 'reports' are "ideological accounts" (Smith, 1990) that conform to the professional organizational management of a "case" and are integral to translating everyday work into a professional frame that can be seen as normalization. The construction of text, as I described the interconnection, stands for 'normalization' no matter what the underlying actuality is.

I have just described a set of documents which make up accountability for services in group homes. Managers become accountable for normalization by recording information in an established manner and circulating them through a bureaucratic hierarchy for review and approval. In a bureaucracy, this textual procedure is commonsense. This is how policy is implemented. However, in group homes, articulating policy and applying it to everyday life is troublesome for managers. In the last section of this chapter and in Chapter Six I discuss how accountability requirements influence negatively the work being carried out in group homes and lives of residents. To add to my argument of normalization

being ideologically constructed, I look to the involvement of ministry social workers in this process.

Professional Knowledge, Accountability and Ruling of Group Homes

Discourses have ideological force when we try to conform our everyday world to interests outside our own. One discourse is conceptually linked with others providing for coordination and articulation of institutional activities. The PSP is an example of experience being organized ideologically through the ruling practice of management technologies in a bureaucratic system within institutional activities. Campbell and Manicom (1995) say "Dorothy Smith wants us to understand "ideology" as not just 'the message' but a set of practices in which things get rewritten *in particular ways*" (p.8). According to Smith (1990), the power of the social organization of "facticity" to subdue and displace the perspectives of particular subjects is a constituent of ideological organization. Smith (1990) says, ideological organization has:

> "a distinctive circularity that insulates the organization of ruling from the effects of disjuncture between the lived actualities as people know them in their "everyday everynight worlds" and the representation of the world as actionable in the textual realities of administration, management, professional discourse and the like" (p. 97).

I contend that what is reported in the PSP and Quarterly Report corresponds to the concepts of normalization formalized in the written text of ministry documents - policies, guidelines, legislation, monitoring mechanisms. This is what co-ordinates the work of managers and professionals. As such the discourse forms the lens through which social service administration and professionals evaluate the work of managers.

As I described in the previous section, the Quarterly Report provides important data for the development and review of the PSP. Group home staff construct reports for the MSS social worker who is responsible for ensuring that policy is implemented. According to MSS policy,

> "the PSP review ensures accountability of the Service Providers (managers) and assures that service delivery conforms to the Ministry Standards of Service for individuals with mental handicaps" (policy, 2.2.1, p.8).

Using reporting forms to complete the PSP review for residents is not foreign to social workers. They have been socialized as professionals in the same way nurses have been to the professional practice of recording their work in documentary form.

In his writings on the work of social workers, de Montigny (1995), says "the proficient use of documents and texts in the form of legislation, policy, manuals, memoranda, and case files, occurs almost automatically as skilled professionals perform their daily work" (p. 209). He goes on to say that "texts" impose an ordered, managed and controlled character onto the messy and chaotic worlds which clients present to social workers. As textual entries are collected into files they become the record of work carried out by the organization. Campbell and Jackson (1992) found that nurses in their schooling were taught to do "accounting" of their work which did not capture or give credit for all that nurses did while delivering care. They say:

> "making accounts match a model or a prevailing system of record keeping rather than making them match the real -life experience of caregiving means that those who have decision making power know only as much as the records tell them and they make decisions on that basis" (Campbell & Jackson, 1992, p. 490).

In other words, where a gap exists in group homes between real life and documentation, decisions made on the basis of records may not fit the real life experience of managers or residents. This could have the effect of managers putting their attention to accountability rather than the actuality of real life experience managing the home (as Campbell and Jackson (1992) suggest about nurses). As a supervisor of nurses, I find that nurses do not record what they actually do in working with their clients. Nurses' work experiences with clients and their work environments become invisible through documentation procedures. Documentation becomes information that management can use for decision making. It does not always reflect nurses' experience. Accounting for work is a recognized management technology. I contend that once "facts" have been entered into the PSP record, it is as de Montigny (1995) argues, that official records gloss over day to day work of managers and their complex relations with residents and staff as well as the relations of power. The relations of power define who contributes to the creation of the record, who has access to it and the organizational uses of the record (PSP). Although this study is not about the work of social workers, their work processes are very much connected with those of managers of group homes. Through factual representation in texts, managers and social workers affirm their power in residents' lives. The PSP constructs an organizationally relevant identity for each resident in the group home. This process constructs their lives as normalized.

Discourse informs managers' work, subordinating their experiential understanding of their work in the lives of people with mental disabilities and transforming it to generalities constructed within ruling relations. Social relations in managers' work, are brought continually into being, coordinating their actions with others. From my interviews with managers I learned there are frustrations

experienced in their work which are not evident in the PSP. These frustrations, as I noted previously, are detailed in the next chapter. The PSP reflects the goals of service for the resident, not the details of issues or the implementation process. Frustrations remain. Managers take responsibility. Officially the hierarchy does not hear. Smith (1990) says that

> "ideological practices ensure that the determinants of our everyday, experienced world remain mysterious by preventing us from making them problems for inquiry. The concept becomes a substitute for reality. It becomes a boundary, a terminus through which inquiry cannot pass. What ought to be explained is treated as fact or as assumption" (p. 43).

How does it happen that 'facts' in organizational documents such as the PSP can differ from the everyday life of group home managers and residents? Smith (1994) talks about "fact" as being socially organized. She contends that facts should not be equated with what actually happened; "fact" as document is not what happened in "raw form". She maintains that in constructing a fact from what happens in everyday life, "that actuality has been assigned descriptive categories and a conceptual structure" (p. 118). Putting her idea into this study reveals that managers' work and their knowledge of residents in group homes is fit into the discrete descriptive categories of the Quarterly Report, and the PSP. These facts are then a social accomplishment. My data reveals that what actually happens in group homes and the lives of people with mental disabilities disappears in the Quarterly Report and the PSP. The actual experience of residents in group homes and the work of managers ceases to be evident when managers' reports are entered into "document time" (Smith, 1990). This understanding is what is submerged in the discourse of normalization. The PSP document appears to speak for itself. To understand this Smith (1994) says,

> "The fixing of a text in an official form, whether by publication or by procedures internal to formal organization, constitutes it as the same on

> each occasion of its reading. ... Upon this depend such forms of organizational consciousness as are typical of contemporary bureaucratic and professional practice."(p. 121).

I have already noted the organizational need for a method of management which holds group homes to action. One that satisfies families as well as public standards. But, in that strategy lies a contradiction. The manager who implements policy is constrained to apply it in a manner that satisfies the accountability requirement. Group home managers must produce the action which is properly reportable. A story which emerged from my data will demonstrate how the requirement for accountability influences decision making.

The Swing

The story of 'the swing' supports my contention that normalization discourse does not equal quality of life; that written policies and requirements for accountable documentation, influence decision making. As a result the everyday needs of residents and the knowledge of these needs may be overlooked and treated as insignificant.

The story comes from a Community Support Worker (CSW) encountered on one of my participant observation experiences who I will call Moira. I made the following fieldnotes:

> "It seems Moira really cares about the residents in the group home and wants what is best for them. We talked about the residents, their likes and dislikes. I was interested in her comment about "N" (a resident in her mid forty's) who Moira said likes swings. She mused about getting a swing for "N" in the backyard, but then added that "they" would never fund a swing. When I asked why, she said it was because it would be seen as treating her like a child. In other words it would not be seen as developmentally appropriate. Later I wondered, if Moira thinks it is a good idea and she knows the resident well, why is that not enough?" (Fieldnotes, March, 1997).

I continued to wonder and question why the community support worker would decide not to pursue getting a swing for the resident when it really seemed that it would be in the best interests of the resident. What was organizing her decision making? I look again to the MSS Community Support Services Policy Manual for Services for Adults with Mental Handicaps. The manual elaborates on five concepts (policy 2.2.2, p. 2-3), which it says are an integral part of all residential standards (applied to group homes). Two of the concepts are useful to my example. One of the concepts "normalization" is described as:

> "the process of making available to people with handicaps those patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society. This includes providing experiences and encouraging characterizations, personal behavior and social roles that are part of the culture and are valued by society.

Another concept, "appropriateness of service" is described this way:

> "the provision of care and supports that are appropriate to the needs and wishes of the individual. This includes supporting behaviors and appearances that are customary and appropriate for each persons' culture and chronological age".

Reading these concepts began to shed some light for me on what might be influencing the community support worker's decision making. The residential standards (and concepts) give direction to managers and caregivers. It is against these standards that their work is measured. I can see that according to these directives, having a swing in the back yard could be seen as treating persons with a mental disability as children and not "supporting behaviors and appearances that are customary and appropriate for each persons' culture and chronological age". Swings, in our culture are seen as an activity for children as opposed to an activity for adults. I contend then that decisions are being made by community

support workers and managers based on policy directives instead of what is in the best interests of residents. I suspect from the managers' point of view having to request funding for a swing could lead the ministry to question his or her commitment to 'normalization' as it is expressed in ministry documents. To document the goal of obtaining a swing on the resident's Quarterly Report and the PSP would not be seen as appropriate because decisions that managers and community support workers make must represent the standard categories of 'normalization'. In other words, it is not just that reporting creates the reality (as fact) but that actions taken 'intend' a particular report, and actions are thus not necessarily the best for each individual.

The use of the term "they" by the community support worker in saying that "they would never fund a swing" (fieldnotes, March, 1997), acknowledges the authority relations in the system. Although community support workers have authority over residents, the request for a swing would have to go through the manager of the group home and the ministry hierarchy. Formal organizations are objectified structures with goals, activities and obligations separate from those of the staff who work for them. It appears the community support workers may also have been socialized to the fact that, as one manager said, "money is tight and if it is not a health and safety issue it will not happen" (fieldnotes, March, 1997). This then precludes asking for the swing. There may be cost-efficiency attached to the decision making. The example of the swing can be seen as an extension of the relations of ruling influencing the work of the community support worker. For the community support worker this can be seen as an example of what George Smith (1995) calls "ruptures of consciousness" (p.21). The community support worker knows what might be beneficial for the resident, but is directed to making decisions that are coordinated to ministry policies and budgets. Control

has been established through the relations of ruling and that control, appears to prioritize interests that are not those of the resident.

The ministry's need to capture an account textually, indeed to demonstrate normalization, is an example of extra-local control over what happens in group homes. What is reported in the categories corresponds to the concepts of normalization formalized in the written text of ministry policy. Authority relations require managers to participate in work processes established by the ministry, as a hierarchical bureaucracy. I contend that managers' work in group homes is creating normalization in text for government (MSS). The managers' focus, in the story of the swing, must be on an accountable activity no matter how difficult. The Quarterly Report and PSP speak in an authoritative voice, not only as a way of transmitting information, but as actual constituents of the decision making process. This, as Jackson (1995) says "makes organizational action more accountable to a framework of externally set goals and objectives" (p. 179). In the case of group homes for people with mental disabilities, ruling practices focus reasonably in producing normalization routinely. However, the text-oriented and discursive organization of managers' work results in the ideological construction of normalization. This ideological organization creates a disjuncture between the world as it is known within the relations of ruling and actual lived experiences.

In the next chapter my analysis of the stories of the managers will explicate this disjuncture. My data will show that, in attempting to adhere to ministry policy in the process of normalizing life for people with mental disabilities in the Capital Regional District, managers work in red tape and cost constraint which actually interferes with normalization.

Chapter Six

Normalization As Text - Normalization As Experience

This chapter examines the disjuncture found as managers work to operationalize 'normalization' in group homes. Managers' 'stories' provide my entry into the relationship between managers' work implementing ministry standards and bureaucratic accountability. In this chapter I show how managers' work must make real or actualize normalization in residents' lives. Chapter five analyzed critically the text mediated processes, showing that normalization remains a textual construct (i.e. an ideological construct). This has implications for managers who work with residents. From my interviews, I saw how managers' 'stories' of their work provides 'the other side' of the ideological construction of normalization. These stories will be analysed in this chapter.

Prior to managers doing work they are responsible for, the life of a person with a mental disability living in a group home is not 'normalized'. Getting services, going to malls, living in neighborhoods, for example 'normalizes' their lives according to program/policy/standards, which are all 'ruling practices' intending specific kinds of actions. However, I found a disjuncture between the discourse, the reported and everyday experience. I will show that making the everyday organization of group homes take the intended shape of standards is becoming more difficult for managers, and that meeting textual criteria is not the same thing as a normal (quality) life. Beginning from the standpoint of managers in group homes I was able to see what their 'issues' or 'problems' are. I was able to see a disjuncture between the ideology of normalization and actualities of managers' experience in group homes. This disjuncture centered on difficulties around activities and social integration; finances and equipment; and neighbors

and home-like environments. These difficulties are discussed in the next sections of this chapter. I have already shown that normalization has been constructed in texts and now we need to see how it appears in everyday life. I will argue that there are real problems in group homes in spite of the text based normalization processes. The other side of text based is experiential. The texts organize what can be done in the home. My analysis of the experiential will show that managers' work and decision making has more to do with meeting bureaucratic requirements than what is necessarily in the best interests of residents.

Activities and Social Integration

In this section I begin with stories from family and health care providers of people with mental disabilities that led me to question some of the decision making that takes place in group homes. I then explore the standards that underlie all attempts by managers to normalize group homes. My analysis of the managers' stories shows that financial troubles underpin more than difficulties obtaining equipment. I contend that there are fiscal policy influences to their decision making that managers themselves may not be aware of. I also suggest that accountability to the MSS via the Quarterly Report and PSP structures the decisions that are made for residents with regard to their activities. I show that 'normalization' when accomplished in peoples' activities looks different than it ought and hence creates a disjuncture between text and actuality.

Decisions made by managers and community support workers regarding social integration and activities for adults with mental disabilities residing in group homes are puzzling to me. My work with nursing staff in Health Services For Community Living (HSCL) and discussions with family members, led me to question how decisions are made with regard to social integration and choice of

activities for these residents. An HSCL nurse became aware of plans to take a resident who was unable to speak, up-island to do some whale-watching. Due to the fragile, medically complex health status of this individual and the lengthy journey required, the nurse expressed concerns about the choice of this activity. On another occasion a family member of a resident expressed concerns related to integration. According to this family member in order to integrate adults with mental disabilities into community there is a perception by some group home staff that residents must be taken out every day. She says residents are taken to shopping malls and musical performances at times when what is needed is for the resident to stay home and rest. In her view, for some residents, the very act of eating a meal consumes their energy, and therefore they need to rest. In order to understand these concerns and come to some understanding of what might be influencing decision making in group homes I look again to the MSS Community Support Services Policy Manual.

The MSS Community Support Services Policy Manual for Services for Adults with Mental Handicaps says:

> "services can no longer be seen solely as provision of care to an individual by a caregiver; they now entail provision of support to minimize the handicaps of that person, to allow him or her, as much as possible, to make choices, solve problems, take responsibility and become self-managing" (Community Support Services Policy Manual, Policy 2.2.2. page 2).

It would seem that in institutions it was care that was provided, but now that residents with mental disabilities are in the community, expectations are different. More is expected in terms of roles and activities of these residents.

The Manual elaborates on concepts that are integral to all of the Standards for Residential Services. These concepts are:

1. Maximizing Development and Growth
   Every person, regardless of severity of handicap, has the potential to grow and develop new skills and competencies. This growth and development occurs throughout a person's lifetime, in steps and at individual rates. People with disabilities need extra supports and opportunities to learn if they are to accomplish this growth and development. They also need to feel the expectation that they can grow and that their efforts have value.

2. Normalization
   Normalization is the process of making available to people with handicaps those patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society. This includes providing experiences and encouraging characterizations, personal behavior and social roles that are part of the culture and are valued by society.

3. Least Restrictive Environment
   The provision of service for each individual in an environment that allows the greatest possible freedom and the least removal from the mainstream of society.

4. Appropriateness of Service
   The provision of care and supports that are appropriate to the needs and wishes of the individual. This includes supporting behaviors and appearances that are customary and appropriate for each person's culture and chronological age. Many options will have to be experienced before the individual can make informed choices about what he or she feels is appropriate.

5. Balancing Risk with Security
   The provision of care which provides for safety and security without being overprotective. All people need challenges to their physical abilities, learning capacity and judgment. When these challenges present an element of risk to the individual, caregivers need to balance the degree of risk with the person's need for dignity and self-determination.

   (Community Support Services Policy Manual, Policy 2.2.2 page 2-3).

These concepts are implicated in the troubles or frustrations that I found managers experience around issues of integration, activities, neighborhoods and

equipment. These issues relate implicitly and explicitly to one or more of the concepts. Attention was drawn in Chapter Five to two of these concepts while discussing the story of the swing.

On further investigation I discovered a memo directed to all Residential Resource (Group Home) Service Providers from a MSS Services To People With Mental Handicaps (SPMH) Supervisor on behalf of the region. The memo contained the following paragraph:

> "The intention of this letter is to provide all contractors with consistent and comprehensive information regarding service delivery in Region L. Our objective is to ensure that all Service Providers both current and future, are aware of ministry expectations, policy and practice. It is our hope that by providing standardized information and clarifying individual roles we will be able to more effectively meet the needs of the individuals we mutually support" (Memo, January 19, 1996).

Once again it would seem that Ministry of Social Services views adherence to standards equating to quality of life for residents. It is also clear that "ministry expectations" are to be complied with. Further documentation related to standardization is found in the guiding principles for Residential Services which are presented in 14 domains (Community Support Services Policy Manual, policy 2.2.2, p. 4-13). These domains were mentioned in chapter four. Here I draw attention to two domains and indicators which have implications for the integration and socialization of adults with mental disabilities into community.

Domain 3: Personal Support

> "says that staff shall actively encourage the involvement of family and friends in the life of the resident. Possible indicators to suggest that this has happened are, "availability of support persons, activities planned with family and friends, opportunities for residents to make friends in their community, and contacts with volunteers" (Policy 2.2.2 page 6).

Domain 11: Activities and Programs

the rationale for this domain states:

> "The foundation of normalization is the provision of daily living experiences that assist individuals with mental handicaps to attain lifestyles, appearances and behaviors that are valued by society as well as by the individual. To achieve this, there must be opportunities for growth and development in the lives of all residents. This includes the indicators, age appropriate day program activities, individual participation in challenging activities, choice in recreation activities, and use of generic, non-segregated resources" (Community Support Services Policy Manual, Policy 2.2.2. page 11).

Policy standards and concepts are part of the discourse of normalization and are meant to give direction to service providers in group homes. The significance of these standards and concepts is not just in the words expressed. Managers must organize activities to actualize these concepts and standards. However, managers' inability to meet individual needs of residents in group homes became apparent in their stories.

Managers expect that residents in group homes will be out of the house each day. During an observation experience in one home, the residents were taken in the house van by the manager to a Day Program. They usually leave at 9:30 a.m. and return home around 3:00 p.m. This day program is run by individuals who have a ministry contract to provide this day service. In other group homes, residents go together to visit malls, go to movies, and go skating etc. Residents going out every day is to be seen as a regular part of life, which for the majority of people usually means going to work. According to a manager of a home with four residents, their day program works quite well for three of the residents, however it is not in the best interest of the fourth. This particular day program is a very active one and "S" (the resident in question) although he is only

in his thirties has a very old body. This active day program is too much for him. He requires a program which provides 1:1 staffing that would meet his individual needs. Despite the manager's attempts to secure a new program for him, funding for this to happen has not been made available. According to the Provincial Standard Review Criteria 8.3.1: "daytime activities e.g. education, recreation, jobs and work experience are in keeping with individual's preferences and interests." One could expect from reading this that individual programs would be available for every resident. However, on further investigation I learned from a Supervisor with Services To People With Mental Handicaps (SPMH) that there are currently 100 people on the wait list for 'Day Programs' and there is no additional funding available for new contracts. Development of specific contracts for resident activity is how the ministry addresses day time activity. It would seem that choices managers make with regard to day time activity for residents has more to do with limitations of financial resources and ministry structure than what is necessarily in the best interests of residents.

Staffing patterns in group homes also influence day program activity. An example of activity programming came from an HSCL nurse about a male resident in a group home. This particular resident no longer wanted to go to his day program. The nurse discovered that he had to go because the group home did not have staff working during the day which would have allowed him to stay home. During an examination of this situation, discussion centered on the resident's age of 50 years. According to Dr. Jim Russell, Medical Consultant for People with Disabilities for the Ministry of Health and Ministry of Social Services, the literature confirms that people with disabilities are usually physiologically 20 years older than their chronological age. This particular resident therefore probably felt like he was 70 years old. A question to ask is whether he ever gets

to retire? In order for this resident to be able to stay home during the day, staffing resources would need to be increased. As it is each home is staffed with a specific resident-staff ratio and according to one manager:

> "Some people feel really comfortable going out on their own with three people (residents) if the fourth one does not want to go out. Some people (staff) don't feel comfortable doing that because they don't feel confident enough that they can handle three people" (Fieldnotes, March, 1997).

Again, we have an example of managers having to make choices for residents based on available funds and staff resources rather than residents' individual needs. Concerns of the HSCL nurse and family member that I referred to at the beginning of this section, begin to make sense. I suspect that given the current absence of staff in group homes during the day, all residents have to go out even if they are too tired, or the event is too demanding for them. Although this fits with ministry policy and concepts, it does not address individual needs of residents.

According to the literature review in Chapter Two, integration as it applies to normalization involves adults with mental disabilities being socially integrated and forming relationships with members of the community. This appears to be interpreted differently by different managers. One manager sees integration as accessing as much of the community as possible:

> "The people that we are looking after they've lived in institutions most of their lives. They've had to get up at the same time every day, they've had to eat their breakfast, lunch, and dinner at the same time every day. All their routine things. Now they are living in a home in the community and they don't have to do that anymore. They are kind of making up for lost time as far as all the social activities that they go to, to movies, to skating ... they probably have a better social life than you or I do because they are going all the time!" (Fieldnotes, February, 1997).

Another manager expressed a somewhat different view:

> "Friendships outside of this house, this is the biggest problem we have. Some of them do maintain some of their old friendships, but most of the people they are friends with are people they are forced to be friends with just as they are forced to live in this house together. They didn't really have a choice of where they were going to be. I think the biggest thing that has to happen is community acceptance. It starts there. I think at we will see more of that through children being in school. Where it is not such a shock to see all these people in wheelchairs that are different. So they are in a wheelchair, so what. We may not see that for a few years" (Fieldnotes, March, 1997).

Are residents able to integrate and become members of groups and clubs that are not specialized for people with a mental disability? One manager told of a resident who had joined a seniors' group and was not well accepted. The manager commented:

> "She was the only handicapped person in the group so you don't have, they sometimes don't have a lot in common with other people and then she started getting a little noisy and stuff. It didn't go over very good so she stopped going" (Fieldnotes, February, 1997).

When I enquired further about the social integration of people with mental disabilities into the community a manager said:

> "I think that it is going to be a long while off. I think, my feeling is that if they had their choice they are going to be more happy associating with people that they know themselves than they are going to some seniors group or whatever. They are not going to know anyone that is there or have anything in common with them. But if they go to another group home to a party or, what we do is that we go skating or bowling in X (a municipality), and we meet other group homes there and we all go together sort of thing. One of the things we try to do is, people that they've lived with at Glendale, we try to keep connecting them to keep things networked. That's important" (Fieldnotes, February, 1997).

Funding and staffing resources discussed earlier, may be implicated here as well with decisions made for integration of residents into community. However, I see another possibility. The reporting mechanism of Quarterly Reports and PSPs provides for managers' accountability to the ministry. Quarterly Reports sent by managers to MSS social workers have category headings about activities and socialization. According to Services For People With Mental Handicaps (SPMH) "Guiding Principles For Residential Service Providers/Staffed Resources" (1996):

> "The contractor (service provider/manager) will connect the individual to his or her community and promote opportunities for leisure and entertainment. These opportunities will be reflected in the Personal Service Plan (PSP) and subsequent follow-up reports submitted to the ministry."

Follow-up reports (Quarterly Reports) on numerous activities that residents participate in, validate the concept of normalization as it has been constructed by the ministry. Missing is the development of interpersonal relationships between residents of group homes and ordinary people in the community. Although the guiding principle outlined under the heading Activities and Programs says "residents shall have the opportunity... to develop satisfying social relationships" (MSS Community Support Services Policy Manual, Policy, 2.2.2. p. 10) it seems the ministry interprets and constructs social integration to "promote opportunities for leisure and entertainment". Without development of social relationships between people with mental disabilities and members of community, there will be lonely people (residents in group homes) whose only relationships are with those who are paid to be there. I contend that reporting activities in the Quarterly Report directs group home staff toward keeping residents on the go, rather than perhaps establishing personal relationships.

Assisting people with mental disabilities to establish personal relationships I am sure takes time and energy. Dedicated people are needed who have the knowledge to do this connecting work and who can provide continuity at the same time. To accomplish this would require education of service providers, managers and staff. Adequate staffing would be needed to provide for individual work with residents. Lack of financial resources to do this could be a barrier to social integration. Reporting activities gives the appearance that integration in the community is happening, however, as was mentioned in the literature review there is a difference between physical and social integration. If residents were kept home all day would it be seen as custodial care? This would not fit with how normalization has been constructed by government.

I believe managers do attempt to follow policy, do required reporting and operationalize integration and socialization as best they can. It seems they understand it in different ways. Some see it being accomplished in 'what they do' while others are more critically reflective. Many managers also point out the constraints under which this must be accomplished, such as money, staffing, and what is available in the community. It is clear that things are not getting any easier. The limited perspective that Lord and Pedlar (1990) found managers had on the concept and practice of community integration may be as a result of the ideological construction of normalization, and the limited success in making residents' everyday lives conform to that ideal. I have demonstrated some practical barriers they face in integration efforts.

Finances and Equipment

To support community living, certain equipment for mobility and seating is required. Normalization is therefore closely related to financial support for it. Managers of group homes are frustrated in their attempts to obtain equipment for residents in group homes. This too, interferes with managers' capacity to actualize their ideals of normalization. In this section I give examples of these frustrations and explore the social relations behind managers' work experiences.

Working with the HSCL program provided me with an opportunity a couple of years ago to meet with managers from group homes. During this meeting managers shared their frustration in obtaining equipment such as wheelchairs for residents. This same frustration emerged in the stories from managers who were interviewed for this study. One manager said:

> "The other thing you get involved with now is, J (a resident) had to have her wheelchair, her specially molded wheelchair updated and that was about $3500.00. Another client has a side-lier that she eats her meals in, and that's falling apart, and that needed to be done. And then we were after a skate board for X (a resident) to put her on the floor and she moves around for different positions and exercise and stuff, so what we had to do rather then just put those three requests in all at the same time, because it was from the same home, we were advised by R (health care professional) to stagger things. So we've got two out of the three approved and we are waiting for awhile before putting in the other one. So, like it can take quite awhile to get all this. These things were identified when we did the "Personal Service Planning" (PSP) last fall so I mean we are into the spring now and we still haven't got it" (fieldnotes, March, 1997).

A crucial point emerging from this manager's experience is that, the request for a wheelchair was identified when the PSP was reviewed "last fall". The manager noted that it is now spring and they still do not have this new chair. Two objectives of the PSP policy which were noted in Chapter Four are worth reviewing:

1. "to ensure that appropriate and effective services for individuals with a mental handicap are provided in an efficient and timely manner; and

2. "to develop jointly with each individual a plan of action that addresses current and future service requirement and supports the individual as independently as possible in the community"
(MSS Community Support Services Manual, Volume 7).

Reading these policy objectives would lead the reader to assume that: residents in group homes are able to receive equipment to meet their needs in an efficient and timely manner; and equipment is seen as crucial support for them to remain independent. As well, when one reads the PSP where resident needs and goals are identified, one assumes the goals of the PSP will be met. However, as I have said previously, managers' experiences implementing the goals is not reflected in the PSP.

A second point emerging from the manager's story highlights the difficulty managers experience when a group home needs to purchase three equipment items at the same time. The manager said,

> "so what we had to do rather then just put those three requests in at the same time, because it was from the same home, we were advised by R (health care professional) to stagger things. So we've got two out of the three approved, and we are waiting for awhile before putting in the other one" (fieldnotes, March, 1997).

Having obtained two out of three requests, this manager is waiting to submit the last request for a specially made skate board which would allow increased resident mobility, exercise, and independence. The 'strategy' the manager is using, to stagger requests for equipment for residents from the same house does not appear to serve residents but relates to how decision-makers view requests of money for normalization related equipment. I have to assume that some

government policy or practice is routinely delaying the spending of money. The individual needs of residents appear to be a secondary consideration. It seems managers have learned to make choices related to ministry budget considerations. Managers' own work, their thinking, and decision making is becoming dominated by financial policies that are penetrating group homes and community living.

Decisions made by managers when equipment costs more than the "magic number of $250.00" (fieldnotes, February, 1997), relates more to bureaucratic processes for obtaining equipment than needs of residents. When costs of purchases are over $250.00 there is a complex, time-consuming process requiring bureaucratic boundaries to be crossed from Ministry of Social Services to Ministry of Human Resources. When speaking about the decision making process for a wheelchair one manager said:

> "the decision is made by some bureaucrat who sees something come across their desk but they have no idea what it is" (fieldnotes, March 1997).

Implied here is that the person with the decision making authority to purchase wheelchairs is many bureaucratic layers away from caregivers who have identified the need for a wheelchair and residents who have the need. The bureaucrat does not have a human face (the resident's) attached to the request. He is merely processing paper. His job apparently is to ensure that there is an equal and judicious distribution of funds. Those who submit requests for large ticket items like wheelchairs know that it is not a good idea to submit more than one at a time. Therefore, when managers make choices to withhold and stagger requests it is serving the interests of bureaucracy and cost-efficiency, not the interests of residents.

The ability of managers to meet the needs of residents in group homes toward normalization is made more difficult by ministry directives. While reviewing the process of equipment purchase, I learned that time lines for replacement of wheelchairs have recently changed. Wheelchairs have in the past been replaced every two years but according to a manager:

> "the criteria has changed and now it (replacement of wheelchair) is every five years. However we have people who are really hard on their chairs and the five years is really pushing it" (fieldnotes, March 1997).

Another example of a ministry directive that makes obtaining necessary resources for residents more difficult is given by a manager who said: "the Financial Assistance Worker (FAW) has been instructed to question every request for clothing to see if it can be cut down" (Fieldnotes, February, 1997). Managers appear to be caught in the ministry's need to curtail spending. This limits individual decision making by managers. The disjuncture that managers experience while attempting to obtain needed equipment for residents for example, arises when normalization is accomplished on paper, and managers are left to put daily life together however they can. It seems to be getting more difficult as other issues take priority.

Requirements of the officially sanctioned record (the PSP) state the goals for residents in group homes but difficulties managers encounter are not part of the discourse. The work they do, the strategies they employ to obtain equipment for residents is never recorded officially. The work of accountability masks actuality in the lives of managers and residents. While being careful with taxpayers money is commendable, I am pointing to instances where I think government concern for 'efficiency', i.e. budget restraint, is interfering with goals of normalization for people with mental disabilities. Being economical is an

'official stance'. Marie Campbell (1996) in her analysis of a quality improvement strategy says that nurses' decisions were being "made accountable to a political agenda of deficit reduction and reduced social spending" (p.23). Reducing amounts of money available for equipment and clothing is an example of how actions in group homes can be thought of in the same way. In other words choices and decisions by managers in group homes are being made to save money for government as opposed to the best interests of residents. This could result in reduced resident mobility, exercise and independence which is in direct opposition to key principles of deinstitutionalization and normalization which were discussed in Chapter Two and are found embedded in ministry documents.

Neighborhoods and Home-like Environments

Managers must work within constraints of neighborhood and community values. Often this creates difficulties for normalizing the lives of residents in group homes. In this section I draw attention to residential standards and describe difficulties that managers experience in trying to meet these standards.

According to MSS Residential Standards (MSS Community Support Services Policy Manual, Policy, 2.2.2, p. 3-14), it is important that group homes for adults with mental disabilities are located in residential areas, close to community services and facilities. The criteria from the Provincial Review Team evaluation process indicates that homes must be in residential areas with a house and yard that promote family style living. For normalization to occur, residents must be integrated into community. The Provincial Review Team criteria states that group homes must be within a 20 minute drive or walk to community services and facilities.

Group homes that I have visited as a result of my work with HSCL and interviews for this study are located in residential areas. The homes are in nice neighborhoods with yards and garden areas which look very much like every other house on the street. Inside, the homes are all different, but generally they each have a living room area with couches, chairs, a television set, and pictures on the walls. There is a dining area with table and chairs connected to the kitchen. Each resident has his or her own bedroom which is decorated to reflect individual differences and personalities. The bathrooms and tub rooms afford privacy. There are laundry, storage, and garage areas. The houses are all wheelchair accessible.

However, as a woman and mother, I know these homes have a different feel to them from homes I know in my personal life. This may be because there are four unrelated adults living together who are dependent for their care on a rotation of paid staff. Everyone is paid to be there and in many of homes there is considerable turnover of staff. As shifts of community support workers change they consult a variety of manuals and procedures to do their work. While attending a British Columbia Association For Community Living (BCACL) conference a couple of years ago, I had a discussion with a person who has a mental disability. He told me that group homes are just like institutions, only smaller. He said that in his group home he is not able to decide when to turn the television off at night because rules of the group home say when that will be. While I was visiting a group home I wondered why a woman who appeared to be about thirty years of age was in pajamas at 7:30 p.m. I suspect it had to do with work processes arranged in relation to the shift that changed at 9 p.m.

Residents of group homes do have a different living environment from what I have heard and seen of institutional life. Institutions I have visited are large, imposing buildings in settings removed from residential areas. Residents in facilities slept dormitory style with at least 10 beds lined up in a row. There were no curtains for privacy, nor was there privacy for residents using the bathroom. For example, in one institution there were six toilets lined up in a room with no stall dividers or doors. Strict schedules and procedures were adhered to on a daily basis. Certainly, physically, group home settings offer a more home-like environment for residents than institutions do. However, achieving and maintaining a home-like setting for people with mental disabilities in community neighborhoods is a struggle for managers of group homes.

Managers in group homes must work through difficult relationships with neighbors and services. A group home which was the first house built in a particular neighborhood experienced the least amount of negativity directed toward it. However, the manager of this home acknowledged there is probably not a group home in Victoria that has not had some problems with neighbours. One of the managers I interviewed made the following comments:

> "I have spent two years in dispute resolution. Our neighbors hate us. They absolutely hate us and have from the beginning. This one person (a neighbour) can't stand the sight of wheelchairs. That's why if you look out there, there is a fence and two rows of trees. Part of that fence is with a sound engineers report. We had to have the carport enclosed. (This was because of the sounds the residents made while getting into the van). When we first moved in here we had a person (resident) who should not have been here and this person created quite a few problems in the neighborhood and we have never been forgiven. Problems, in terms of noise and pounding on peoples' doors at 3 a.m. When X (a resident) is happy she shrieks and it bothers a fireman, (who is a neighbor) because it is the noise he hears in fires. (Fieldnotes, March, 1997).

The need to enclose the carport so neighbors do not hear residents being loaded into the house van and the need for a fence and two rows of trees is very graphic when describing the lack of acceptance from neighbors. A manager said:

> "there has been ongoing problems with tenants and other people that live in the building between our clients and other people that live in the building regarding complaints of noise and stuff like that" (Fieldnotes, February, 1997).

Another example of a situation with neighbors was described by one of the managers I interviewed:

> "that's another thing where the manager really gets involved up to their ears is dealing with the neighbors. I don't think there is a group home in Victoria that hasn't had problems with the neighbors. At XYZ (a group home), every once and awhile we have problems with the neighbors because of the way the place is. There is an easement there and the neighbors seem to think that they control the easement. And if anyone comes to visit us and parks on their easement they get on the phone to complain. Little things like that. When we first moved in, they were not too pleased because they thought their property was being devalued because you know the same old thing, their property rates were going to go down because of handicapped people. They were worried because of the traffic coming and going and the service, like we have milk delivered, laundry delivered and supplies delivered and they were all real snarky about all that kind of stuff. But we have invited them to some of our parties and things like that and we get along pretty good with them now ...You like to think that handicapped people are well accepted within the community, but I think we still have a long way to go for that" (Fieldnotes, February, 1997).

Community acceptance in residential neighborhoods is a major issue in community living for people with mental disabilities. The decision to deinstitutionalize people with mental disabilities was made against a history of putting individuals with disabilities in institutions. My background in nursing includes working in the 1970's on a Paediatric Unit in a local hospital which also included Neonatal Intensive Care. I recall on a particular occasion a physician recommending to parents that they not take their daughter home, but instead

encouraged them to put her into an institution. She had been diagnosed with spina bifida and a mental disability. Even then it was not considered the norm for a family to raise a child with a mental disability at home. Are we expecting too much when we assume that neighborhood communities will welcome with open arms group homes for people with mental disabilities?

Community reaction to people with mental disabilities is rarely talked about. It appears to be suppressed. As recently as June 21, 1997, the Times-Colonist newspaper reported a controversy with regard to establishing a group home in the municipality of Esquimalt. Government provided no official comment about the issue, and purchase of the home was eventually withdrawn by the Service Provider who said "I have to decide if moving into an area where we are not welcome is in the best interest of those we support" (Times-Colonist, Letter to the Editor, June 21, 1997). Service providers and managers are left to deal with issues of non-acceptance.

Letters to the editor in the Times-Colonist (June 21, 1997) offered different view points. One letter described a person's negative experience living next door to a group home which entailed residents throwing rocks into her yard, rude gestures, urinating outside and obscene language. In contrast there were other letters commenting that not allowing people with disabilities into a neighborhood suggests the same kind of segregation that African-Canadians have suffered for years. Some people in Esquimalt said they do not have anything against people with disabilities but felt that the group home for adults with a mental disability did not belong in their neighborhood. I found it helpful to reflect on my own personal experience living across the street from a person with a mental disability.

I live in a middle class neighborhood. When my family moved into our home twenty years ago, there was (and still is) a man named "Dan" living across the street. He was at that time in his early 20's and had a severe mental disability. We learned he was not capable of speaking, but communicated by shouting and making loud noises which he did quite often. His shouting was quite distracting at first, but after awhile it became a familiar neighborhood sound, so much so that when visitors to our home commented on the 'noise' outside I had to admit I had not even noticed. What we did know about Dan is that he liked to be talked to, to have his hand shook and to have his back and head rubbed. He also had a collection of pop bottle caps to which our young daughters liked to contribute. I have observed during the past twenty years that although there were many people who stopped to chat with Dan and his parents, there were many who crossed the street to avoid having to do that. I know of children who were afraid of him, and whose parents did nothing to dispel that fear. I can only speculate that they had fears of their own. I suggest that even today it is fear of the unknown and society's aversion to people who are different which confronts neighborhoods when they are expected to accept people with mental disabilities into their midst. I recognize too that I have had personal experience with one person with a mental disability living across the street, not the four people who live in group homes in Victoria. If I were honest, I am not sure that I would want the noise of four "Dans" living across the street. One of the managers I interviewed is a staunch supporter of people with mental disabilities and advocates for group homes that are smaller. This manager would like to see a time when people with mental disabilities will:

> " be more independent, maybe an apartment kind of thing. Or a home too, with a smaller number of people. That is something I would like to see. Four is too many, two would be nice" (Fieldnotes, March, 1997).

In addition to the problems of living in neighborhoods, the managers shared their stories of other challenges in using neighborhood services which they face on an ongoing basis. These challenges range from: difficulty getting bank cards for residents; to library staff questioning why a person with a mental disability would want to take out a book; to an anaethesiologist referring to a resident who was having some dental work done under anaesthesia as an "it". It seems that these are the ongoing challenges of fitting into neighborhoods, and into everyday life in a 'normal' way. It is important to note that these difficulties are created not by people with mental disabilities, rather, they are created by outsiders, the community into which people with disabilities want to fit.

Yes, there are standards and criteria for residential homes in communities. This does not change the fact that managers' work involves addressing issues of non-acceptance in neighborhoods. It takes time to deal with these issues. This is part of managers' work that is never 'officially' acknowledged. In other words, it is not required to be documented. If documentation validates reality then these difficulties the managers experience are not recognized.

Creating a nice home-like environment is also the manager's job but they are experiencing difficulties accomplishing this. There are barriers in attempting to meet standards of providing a well maintained home for residents. According to the MSS Residential Standards used by the Provincial Review Team to evaluate group homes, there is a domain entitled "Home Environment: Home Environment Promotes family Style Living". Under this heading there is item 1.2.5 which has as criteria "the home is well maintained, furnishings are comfortable, decoration reflects the individuals personal tastes". Standard questions used by the review team to evaluate this criteria are: Are the

furnishings and decor comfortable? Is there interior maintenance of the house? Is there cleanliness of the house? (Report, Provincial Review Team, p.2). It can be difficult to maintain a group home according to standards. One manager voiced frustration saying:

> " our dining room table needs to be refinished, and has for a long time, but the money just hasn't been there. And now the money is there but I think the last time we had a quote was about three years ago. I see it falling apart and looking grungy and I want to have it done right now! But as long as it's not a health and safety issue, with the restraint of the last couple of years," (pause) (Fieldnotes, March, 1997).

Another manager worked for over five months to get funding to repaint the inside of the group home. Many residents in group homes use wheelchairs. The goal of maintaining independence and mobility of these residents results in walls and doorways being run into and chipped. As well, 60-70 percent of this population are diagnosed with some form of seizure activity, and during a seizure, walls can be damaged from helmets or the flinging of legs. This is part of a normal day in a group home. Managers are frustrated when they are unable to maintain the interior maintenance of homes. This inability appears to be limited by financial resources.

What will happen if resources for people with mental disabilities are further reduced? The ability to keep the yard groomed and house in good repair to fit in with neighborhoods will be more challenging. If resources are reduced there perhaps would not be enough staff in the home to do this kind of work. Perhaps homes would need to be grouped together to reduce the number of houses that need to be maintained. If larger group homes are deemed necessary they may have to be built on larger sections of land in outer areas of the city where land tends to be less expensive. It begins to sound like a return to larger facilities,

away from residential neighborhoods and away from the concept of community living and normalization for adults with mental disabilities.

The ideological practice that was described in Chapter Five is an actual 'operation' in the managers work process. The manager has a plan (PSP) for the resident which organizes her/his work and therefore the residents' daily experience. But, is it normalizing the residents life? Yes, if you look to the principles, standards, plans and records that change hands. However, that account is ideological. By following procedures that create/construct normalized lives, I contend that the ministry believes this becomes 'normalization' for residents. My critique is that what is created is an ideological construction, not a normal (quality) life. It is something that can be shown to accountably be a 'normalized' life. This of course is ideological practice.

I demonstrated in this chapter, there is a disjuncture between the ideology of normalization and the 'actual' experience of residents and managers. Troubles with social integration, activities, obtaining equipment, and acceptance by neighborhoods, are very real no matter how sucessfully documentation communicates 'normalization'.

Chapter Seven

Managers' Work - What I Have Learned

My goal in this thesis has not been to evaluate managers' work or the quality of group homes for adults with mental disabilities, but to provide an analytic contribution of knowledge. My exposure to Health Services for Community Living (HSCL) directed me toward the work of managers in group homes for adults with mental disabilities because of the centrality of their position in these peoples' lives. In this chapter I discuss what I have learned about managers' work and offer brief comments about the implications of this for managers.

This study and the analysis of ministry documents showed how efforts of managers and community support workers are mediated by a discourse driven process which objectifies residents in group homes.

Residents become the object of normalization plans and activities and as subjects they are ruled by these practices. I provide insight into the reasons residents experience life as they do and managers' work is organized as it is. I maintain that the language of 'normalization' suppresses the fact that 'client systems' are linked to 'resource systems' and that funding issues may take priority. The PSP focuses on an individual approach to services which may appear to be a slightly different approach than normalizing the environment which is what was suggested by Wolfensberger (1972). Managers of group homes are struggling to fill gaps in order for community living to be successful for their residents. I have demonstrated and suggested many constraints that managers face in doing their

jobs. These findings suggest that accountability to bureaucracy may serve government but may not be assisting people with mental disabilities to a quality (normal) life. Acountability to ministry staff using acceptable language, required criteria and so on, actually generates an account as normalization.

For the ministry, accountability means standards are met, but for managers accountability becomes an additional burden that absorbs work time. One manager expressed it this way:

> "not enough hours in the day. Priorizing is hard. Money has always been tight, it is the squeaky wheel that gets the grease. The time to document everything, the accountability. Documentation is time consuming. I need it to make things run smoother. I need to know everything that is going on. I have told the staff they can call me when I am off" (Fieldnotes, March, 1997).

"The time to document everything, the accountability" is a major issue for managers. To address "accountability" for proper management of funds and services to residents, managers have set up internal monitoring systems in group homes. These systems record, for example, purchases, petty cash expenditures, resident bank accounts (for MSS money, and personal money), as well as charting systems which document everything that happens to residents during daily shifts of workers. This documentation is used for completing Quarterly Reports. Staffing schedules and payroll sheets also need to be done. The above list is not meant to be all inclusive, but to give examples of the accountability expected of managers. The intent of monitoring systems is the same in each group home although they are developed independently. Developing and coordinating record keeping systems is a specialized task.

In addition to accountability reports, managers develop manuals used by staff, the community support workers. One example is the "Individual Care Plan" manual which is a systematic recording of a residents' life and care requirements. Managers recognize that documentary information is not the best way for new staff to get to know residents. One manager said:

> "There is a lot that new staff have to learn and read about the people (the residents) It's difficult to read it and get to know the person. They really have to get to know the person and read the information at the same time" (Fieldnotes, March, 1997).

This manager is already aware there is a gap (disjuncture) between experiential knowledge and objective knowledge. The problem the manager is describing, of course, is the process of textual mediation of reality (Smith, 1984, 1990). The manager recognizes that a resident's life does not exactly fit with documentary reality constructed in reports. Just as I have shown that 'actual' life in a community group home does not exactly fit with the ideological construction of normalization by the ministry and the textual work of managers.

Managers use more than their allotted time to accomplish the administrative/business part of their work in group homes. In group home contracts, administrative work is to be 40%. All managers indicate that it takes more time than that. Information I received from the interviews suggests that managers spend at least 60% of their work time addressing accountability. This work is done in the group home 'office'. According to the Ministry of Social Services, group homes are not to have 'offices'. Therefore, the room in a group home which has the desk, computer or copying machine is usually called the 'staff room'. Although managers say this room is not off limits to residents, it seems they do not use it. According to Provincial Review Team criteria 1.2.4. "office

business does not intrude on living space or activities". It would appear that the ministry is attempting to downplay the 'business' side of community services and the time it takes to accomplish the required accountability.

Managers' responsibility for maintaining accountability is spelled out in group home contracts with the ministry. Group homes in this study are dependent on ministry funding. As a manager myself, although in another agency, I recognize the ministry does need to have some accounting for funding and quality of services in group homes because they are not involved in day to day operations. However it is important to recognize that this documentary reality references organizational requirements of the ministry, it does not represent the entirety of what actually happens in group homes. Accountability and paperwork become routine, and managers see it as something that needs to be done no matter how much time it takes. That is just the way it is. Ideologies are processes that are produced and constructed through human activities. The work processes that were explicated in Chapter Five producing the ideology of normalization are invisible. Once written up, the text stands as what actually happens. Managers complain about too much documentation and administrative work but come to accept it as part of the accountability that is required.

Based on the findings of my analysis, there is a clear contradiction in managers' work. The tighter the documentary methods of accountability to the ministry for 'good work' means that more and more time goes into making 'good work' appear on paper. This does not address the real life troubles that managers face. What managers see to do, can then be seen as 'meeting standards'. As I suggested in the story of the swing, their work must be made to have a text-based 'reality'. This adds enormously to the managers' workload as their whole

work process is held in place by meeting bureaucratic reporting requirements for accountability and funding. I demonstrate in Chapter Five and Chapter Six that normalization is constructed through reporting of certain activities and that this accountability is an essential bureaucratic requirement. Despite the best intentions of managers there are choices and decisions made that do not always appear to be in residents best interests but are designed to serve organizational requirements. This contradiction in managers' work produces as Ng (1988) found "a persistent tension between provision of service for clients and the rising demand for producing documentary materials" (p. 13). She describes how production of various kinds of data (financial and performance) is key to community groups' ability to obtain and secure funding. This also ties groups (eg. group homes) to ruling regimes. "Indeed it can be said that in contemporary societies, ruling is encoded largely in documentary processes such as in legislation, orders in council, interdepartmental memoranda, and contracts" (Ng, Muller, & Walker, 1990, p. 316). This encoding and coordination of administrative practices keeps bureaucratic practice in place.

Managers' ability to operationalize the goals of the PSP is not getting any easier. While managers are putting more and more time into 'accounting' work they are not doing other things. I contend that the time spent administratively prevents managers from, as an example, doing more with staff orientation and education or doing more in the area of social integration and personal relationships in the community for group home residents. I suggest that a consequence of not building these relationships could be the suggestion, that other than people having a nicer place to live, there is little benefit of community living for adults with mental disabilities. As I point out in Chapter Six, community living is a slippery slope already being impacted by loss of adequate

resourcing. As resources are reduced, and managers' work is increasingly taken up with administrative tasks that seem unrelated to residents themselves, the viability of community living is eroded. Reduced availability of all necessary resources could move community living toward re-institutionalization, particularly if it is seen to be less expensive. McQuaig (1993) talks about the world of the market place, and how difficult it is to maintain political support for services (like those for people with a mental disability) within a marginal population when only a few benefit.

I also contend that normalization discourse organizes managers' work in ways that are not visible to managers themselves. According to Ng (1995), "ruling does not only involve politicians and government officials; it occurs in many sites simultaneously, involving vast numbers of people who do not consider themselves part of 'government' "(p. 38). It is quite likely that managers of group homes do not see themselves doing the work of ruling. According to Ng, Muller and Walker (1990), we no longer can talk about the state as if it stands "over and above us". They say that if we as workers (nurses, social workers, managers etc.) participate in administering some kind of ruling documentary process, this implicates us in ruling activities. This is because the documentary mode of management enters local settings such as group homes and connects them to action at different levels of government.

Having knowledge about how the system works, how the work of managers is embedded in a larger system can assist a manager to know what kind of stance he or she will take. As a manager myself, I feel at times that I am straddling two worlds. The world as I know it organizationally and the world I know from experience. I have learned about the problems of traditional policy

implementation for group home managers. As I noted, a standard method of policy implementation in bureaucracies is a text-based accountability system utilizing standards, documents and work processes. I have learned that no matter how thoroughly this accountability process is accomplished, or in fact how competently a policy is implemented there are still problems for managers and residents in group homes. Managers who implement policy are constrained to apply it in a manner that satisfies accountability requirements. This influences managers' decision making and does not officially recognize the problems they encounter. I do not see that changing policy is the answer here. However, perhaps looking at how policy is implemented might be helpful. I believe that ruling functions need to be more responsive to different kinds of knowing and not just rely on the official version. I have come to understand the difference between the 'official' version and 'experience'. Experience is important knowledge and it is here that the power to act as a change agent resides. If we understand that knowledge is socially constructed, then there can be change. Managers in group homes need to be supported to be more critical of what they are doing even though critical consciousness disrupts the authority of official knowledge. A critical perspective is one that I also can work on in my own practice.

As a feminist, and having come to understand the difference between the 'official' version and 'experience', I will attend in my own practice with more appreciation for the experiential knowledge that staff bring. Now I have a way of supporting the validity of this kind of knowledge. I know that the rational, technical approach of official knowledge has its flaws. With the authority I have as a manager, I can now read objective accounts of work with a different understanding. I can never put my whole belief in these official accounts as I

cannot argue that they provide whole knowledge. A major problem of course is that knowledge of professionals is subordinate to the official version which is seen as more scientific. That is why, in order to have a complete picture, both official and experiential knowledge must be used.

Group home managers need skills in both 'worlds' if they are to be successful with their jobs. I have attempted to provide a systematic understanding of group home managers' work trying as Marie Campbell (1996) says, "to open up possibilities for people who live these experiences to have more room to move and act, on the basis of more knowledge about them" (p. 1). If the lives and experiences of group home residents are to be expanded, then the managers must be able to negotiate on their behalf and not be satisfied with 'meeting standards' in a text-based practice.

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Appendix A

Information for Managers of Group Homes on the Research Project Entitled:

"CREATING A COMMUNITY-BASED HOME FOR PEOPLE WITH MENTAL DISABILITIES: THE WORK OF GROUP HOME MANAGERS"

In addition to working as Assistant Manager with the Capital Regional District's Home Nursing Care program, I am completing studies toward a Masters Degree in Nursing through the Faculty of Human and Social Development at the University of Victoria. As part of my studies I am expected to undertake a research project to complete a thesis.

My research interest is in the 'work' of managers in group homes for people with mental disabilities. This would involve a research process where I would talk with managers about their everyday experience as a manager: what they do, how they do it, who they relate to, what documents and written material are part of their work life. I would also like to spend some time observing part of a day in the life of a manager. This data collection would include fieldnotes and audio taping of the interviews with managers.

When managers agree to be interviewed, this is arranged individually and the manager will be asked to sign a separate consent form (attached). The managers who participate will not be identified and the results of the study will in no way identify them. I am interested in themes, similarities and differences that run throughout the information, not individual behaviour or ideas. This research is not intended as an evaluation of what is good/bad or right/wrong. The goal of the research is to find out how the work of a manager is organized in relation to the larger picture related to government, health and social service systems.

This research is independent of the Capital Regional District, Ministry of Health and Ministry of Children and Families, although they are informed and have given agreement to the researcher to access general data about the contracting process etc.

Thankyou for considering participating in this research project.

Researcher - B. Lee Drummond
Phone 598-8770

Appendix B

CONSENT FORM FOR PARTICIPATION IN THE STUDY ENTITLED:

"CREATING A COMMUNITY-BASED HOME FOR PEOPLE WITH MENTAL DISABILITIES: THE WORK OF GROUP HOME MANAGERS"

Researcher: B. Lee Drummond

I, ...consent to participate in the study to examine the 'work' of managers in group homes for adults with mental disabilities. I understand that my involvement in this study is completely voluntary and that I may decide to withdraw at any point without negative consequences.

I understand the purpose of the research is to explore what managers in group homes do to normalize the lives of people with mental disabilities. It will also explore how managers work is affected by features of organization outside their control, and may give managers a greater understanding of how their work is organized.

I am aware that I will be interviewed by the researcher at a mutually agreeable time and place and asked a series of questions relating to my experiences working as a manager in a group home. I may be asked to participate in an interview of 1-2 hours on one or more occasions. These interviews will be tape recorded and notes may be taken. This information will be stored in a locked cabinet and will be available only to the researcher and her committee. The tapes will be destroyed and field notes shredded on completion of the thesis.

I am also aware that the researcher may make arrangement to spend time with me and observe my work on one or more occasions.

I understand that should I withdraw midstream the researcher will use as data the interview results collected to that point.

Due to the small sample size of managers, there is a possibility that confidentiality could be compromised. However, I am aware that my involvement in this project will be kept strictly confidential by the researcher and her supervisory committee. The results of the study, published or unpublished will in no way identify me. Code numbers will be used to identify the results and the participants names will not appear on any documentation.

If I have concerns about the conduct of the research or the graduate student researcher, I can contact the researcher at 598-8770, or her supervisor, Dr. Marie Campbell at the University of Victoria, 721-8203.

The above information has been reviewed with me by the researcher.

Signed.....

Date.....

VITA

Surname: Drummond Given Names: Brenda Lee

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University of Victoria	1993 to 1998
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Royal Jubilee Hospital School of Nursing	1967 to 1970
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Nursing Diploma	1970

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Title of Thesis:

Creating Home in Community: The Social Construction of Normalization

Auth[redacted]

Brenda Lee Drummond

April 30, 1998