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THE ILLUSION OF INCLUSION:

An Analysis of Participation, Empowerment and Community-Based Decision-Making in Mental Health Planning

by

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ABSTRACT

This study explores how participation, empowerment and community-based decision-making materialize in the everyday world of consumers and community members seeking to be involved in policy and planning for publicly-funded government mental health services.

Using a method of inquiry called institutional ethnography and working within a participatory framework, data was collected through participant observation, documentary analysis and interviews over a period of 10 months. Using the experience of those with less power (consumers, family members and a community advisory group) as the entry point to the study and then linking those experiences to the larger organizational and political context provided an examination of the activities and social relations that construct "participation" "empowerment" and "community-based decision-making".

The analysis revealed two sets of practices arising from two different paradigms of action that worked together to create compliance and an acceptance of non decision-making by the community group. Facilitative practices, designed to create opportunities for inclusion, worked in conjunction with the set of decision-making practices that dominate government bureaucracies to create an environment where community members began to organize themselves to have less involvement in decision-making. This "knitting together" of the apparently contradictory sets of practices as ruling relations served to keep community members feeling good, viewed as competent

contributors to community planning processes, but disempowered, and created the illusion of participation and inclusion.

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Table of Contents

APPENDICES

List of Figures

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Chapter 1

Introduction

> Staff meeting was really depressing today. Each one of us had an experience this week where someone in the community questioned the "real" purpose of all the "participation" we are supposed to be facilitating. It's depressing because there is a part of me that wonders too. I feel that we are all very good at saying "participation and empowerment" but it sure seems that in spite of our best efforts it often doesn't happen. I really believe people participating will result in better health and better decisions but somehow I don't think me believing it or working really hard at trying to make it happen is enough. There is something else going on .... I wish I knew how to figure it out.
>
> (Personal Journal, June 1991)

As a nurse in community practice, using community development principles, I am aware that policy and practice frameworks in health, have been barraged over the past ten years with a variety of terms which refer to increased community participation in the policy making and implementation process. Examples of terms used include 'meaningful consumer participation', 'collaboration', 'partnership with stakeholders' and 'public participation'. With the election of the New Democratic Party in the Province of British Columbia in 1991, the release of "Closer To Home: The Report of the Royal Commission on Health Care and Costs" (1991), and the Government's response to the Royal Commission, "New Directions for a Healthy British Columbia" (1993), new recommendations and policy directives in the health care field have abounded. Integral to these directives is the inclusion of community groups and recipients of service (called "consumers", within these "new" frameworks) in all areas of policy making, planning and program delivery for health and health care.

I essentially support these initiatives and welcome the philosophical shift that they appear to represent. I believe these recommendations and policy directives represent the World Health Organization's (W.H.O., 1984) 'Health for All' objective. This objective illuminates the need and supports the value of empowering front-line workers, recipients of service, and community members through community building processes.

However, as the "participation" terminology became more and more part of the mainstream discourse, I felt a vague discomfort with accepting these directives without question. I recognized that this discomfort was arising from my experiences, being involved in and facilitating community participation and decision-making processes and I knew it was somehow related to the tension between what was being said and what was actually happening. I have had many experiences at attempting to promote community participation and decision-making where, with both my own and my colleagues' skill, experience and best intentions, the result was neither participatory decision-making nor empowerment. I knew from my experience that the ideology of participation was relatively easy to talk about and to defend. People responded positively and liked the "idea" of participation. I also knew that there was a link between empowerment and participation. What I struggled with was what participation and empowerment actually looked and felt like in practice, how they were linked together in actual experiences and what the "something else", that I could only describe as an uncomfortable feeling, was. Further explication seemed out of my reach.

This study is part of my quest to understand how participation, decision-making and empowerment of citizens and community members works in order to enhance my practice and hopefully to contribute to the understanding of inclusion and participation in policy and planning for health. I have done this by using interpretive methodology to explore, beginning with the experiences of those with less power and then linking those experiences to the larger organizational and political context, how the activities of people are coordinated or linked together to construct "participation", "empowerment" and "community-based decision-making" within a publicly-funded government contracted initiative.

Through my employment, I was provided an opportunity to work with an advisory committee of people involved in a participatory process for decision-making in the mental health field. The struggle for meaningful participation by citizens and recipients of service is particularly prevalent in the mental health field where the ideology of consumer participation has been at the forefront of discussions for several years.

I decided to work with the advisory committee and designed a participatory research project that used a method of inquiry called institutional ethnography (Smith, 1987). I chose participatory research in order to connect my actions as a researcher with the topic to be studied (Maguire, 1987). I felt strongly that in order to study empowerment and to be congruent with the aims of the participatory process in mental health I had to act in a participatory way as a researcher. I chose institutional ethnography because it appeared to be a research methodology that would allow me to uncover the "something else" or that which my immediate experience as a facilitator of participatory processes could not explicate. Institutional ethnography "seeks to locate the dynamics of a local setting in the complex institutional relations organizing the local dynamics" (Ng, 1988). In this case, my discomfort and the dynamics of the participation of the local group couldn't be understood without situating it within the historical, political and organizational context that gave rise to the experience.

As I became involved with the advisory committee and listened to people, I was particularly focused on what happened in the name of "participation", "empowerment" and "community-based decision-making". As time went on, I began to see empowerment from a number of places and two interrelated but somewhat different perspectives of empowerment emerged. People talked about their personal experiences of feeling empowered and about their collective experiences as a community struggling to make decisions and be self-determining. As the process of analysis unfolded, I also began to understand practices or actions that either contributed to or detracted from people's sense of empowerment and power to influence decisions. I began to see many tensions and contradictions and came to see two sets of practices that worked together. Facilitative practices, associated with empowerment and community development, included modelling inclusive behaviour, information sharing, linking groups together, active listening and respect. Decision-making practices, associated with bureaucratic and budget-making processes, included practices that separate subjective experience from decision-making through documentation, categorization, priority setting and complex arrangements of reporting relationships and hierarchies. These decision-making practices can be considered management technologies designed to control. I use the word "technology" here as Ursula Franklin explains it in her book "The Real World of Technology (1990). She talks about technology as "practice and the organization of work and of people" (1990, pg.12). She says "technology is not the sum of the artifacts, of the wheels and gears, of the rails and electronic transmitters. Technology is a system. It entails far more than its individual material components. Technology involves organization, procedures, symbols, new words, equations, and most of all, a mindset." (Franklin, 1990, pg.12). Further, she says that technology must be examined as an agent of power and control.

Together these two apparently contradictory sets of practices actually complemented one another to construct acceptance of non-participation in decision-making on the part of community members. Facilitative practices became a method of management or a management technology that actually facilitated the acceptance by community members, without conflict, of bureaucratic decision-making practices that maintained control centrally and provided a barrier to community decision-making ability. Seen this way, working with people in communities in what the theorists call an empowering way actually created disempowerment

Figure 1 depicts diagrammatically the perspective I am taking and represents the relationship between personal and community empowerment and facilitative and decision-making practices. It shows the disjuncture between personal and community empowerment and decision-making practices and community empowerment. My research has been to discover not only where there are disjunctures but also to unravel how they happen.

Further, I am arguing that the two sets of practices identified arise from competing paradigms of governance. Facilitative practices arise from an inclusive paradigm, characterized by the valuing of self-responsibility, shared expertise, contextually defined experiences and multiple realities whereas decision-making practices continue to flow from the traditional paradigm, characterized by values embedded in rationality, logic, objective knowing, a single truth or right way and the value of experts. This traditional paradigm of governance continues to be embedded in bureaucratic and professional practice while the policy framework towards participation, empowerment and community-based decision-making is based in an inclusive paradigm of governance. Furthermore, the current policy discourse on health in British Columbia continues to make invisible the domination of the traditional paradigm in bureaucratic and professional practice. I argue that disseminating ideas, making value statements, inviting participation and changing structures alone will not create power shifts and opportunities for community participation. My research suggests that the dominant paradigm needs to shift to create decision-making practices that reflect the characteristics of an inclusive paradigm of governance. It seems apparent that inclusion will continue to be an illusion unless there is an ongoing analysis of traditional bureaucratic and professional practice in order to make visible the embedded practices that continue to organize participation and empowerment away from local control.

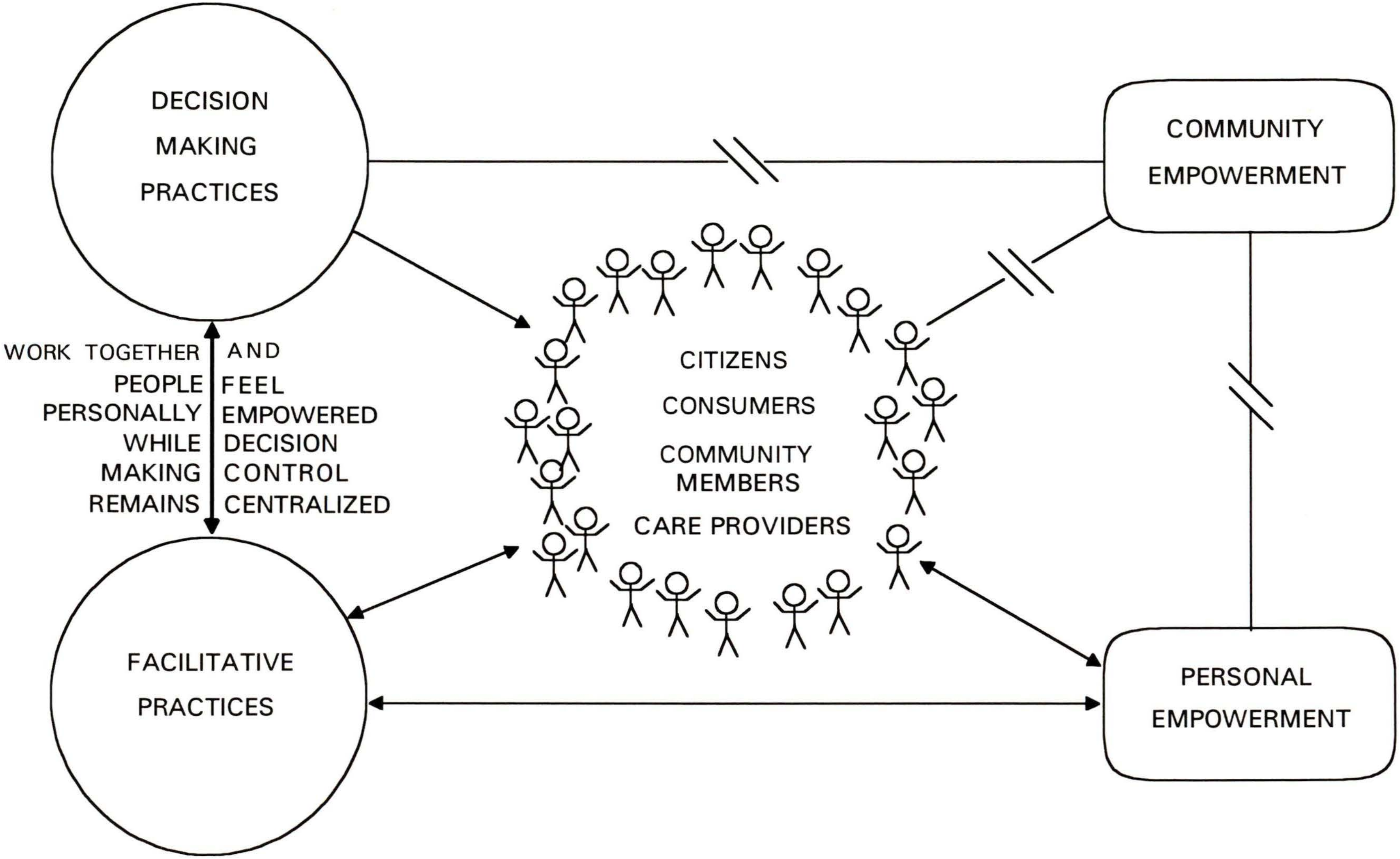
DECISION MAKING PRACTICES
COMMUNITY EMPOWERMENT
WORK TOGETHER AND
PEOPLE FEEL
PERSONALLY EMPOWERED
WHILE DECISION
MAKING CONTROL
REMAINS CENTRALIZED
CITIZENS
CONSUMERS
COMMUNITY MEMBERS
CARE PROVIDERS
FACILITATIVE PRACTICES
PERSONAL EMPOWERMENT

FIGURE 1

I want to devote a few words to the concept of intent and make it clear that throughout my research I did not meet anyone who was intending to create disempowerment. There is no "back room plot" or "conspiracy" to make community participation in decision-making fail. In fact, there is a lot of energy and honest commitment to making it succeed. The sad thing is that it may not succeed because most actors in the participation drama cannot see that our experiences are organized as social relations in such a way that the status quo is maintained. I use myself as an example. I am and continue to be totally committed to the ideology of participation and yet I discovered that I acted, with the most exemplary intentions and a high level of skill, in a way that contributed to the failure of community participation in decision-making. The exciting thing is that I discovered it and now have some insight and ability to change my actions. I hope that others read this study and feel the excitement of that discovery and can apply it to some of their behaviours.

In chapter two, I develop a conceptual framework from which to study community participation, empowerment and decision-making related to mental health planning. Chapter three outlines the methodology I used in more detail. Chapter four traces the development of the advisory committee and describes my mandate with them. Chapter five describes our (both mine and members of the advisory committee) experience of participation. Chapter six uncovers the two sets of practices associated with my facilitation of the group's process of decision-making and explores the contradictory results. Chapter seven examines the current health policy framework in British Columbia and explores paradigm and practice connections.

Chapter eight describes the impact of the analysis on myself and the advisory committee.

Chapter 2

Review Of Related Literature

I developed a conceptual framework through reviewing literature pertaining to:

1. the theoretical work relevant to community participation;
2. research regarding community and user participation in the mental health field;
3. research methodologies being used in the health promotion, community participation and mental health fields.

As I worked through the literature, I looked for ways in which the literature made sense or not of the problem of participation, empowerment and community-based decision-making and of my experience and the experience of the advisory committee. Using the literature, I gradually built my conceptual framework throughout the research process. Although when documented the concepts are separated and the building of my conceptual framework appears to be a linear process, it was not. The concepts are inter-related and the building process was a reflexive one. That is, I used the literature to guide my study and I used my research experience to guide my review of the literature.

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Review Of Theoretical Literature

The literature which contributes to theorizing about the participation of community members in policy development and decision-making is extensive. I looked to current definitions and writings about the concepts of mental health and mental health promotion; community member participation in decision-making; power and empowerment; social relations and organizational theory and practice in order to enhance my analysis.

Mental Health and Mental Health Promotion

I began by looking for current definitions and policy frameworks nationally and internationally that gave rise to the current trend towards community participation. It would appear that redefined visions of health and health promotion in directives from both the World Health Organization and Health and Welfare Canada supported and in some cases initiated the current discourse in health and health care.

Currently, the best known and most universally accepted definitions of health are: "the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs: and on the other hand, to change or cope with the environment" (World Health Organization (WHO), 1984, p.3) and "a resource for everyday life" (Ottawa Charter for Health Promotion, 1986, p.2). Labonte (1989, p.24) defines health as "an intrinsically holistic concept", "more than our notion of individual behaviour" and "beyond the complex web of social conditions". He says "essentially health exists in the dynamic moments of our social relationships" (Labonte, 1990, pg. 24).

Health promotion, defined by the World Health Organization (in Epp, 1986, p.5) is "the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health". The concept of health promotion represents "a mediating strategy between people and their environments, combining personal choice with social responsibility for health" (WHO, 1984, p.4).

In the Canadian Health and Welfare document "Achieving Health for All: A Framework for Health Promotion", Epp (1986) outlines three

three challenges to Canadians if the goal of health is to be met. These challenges, reducing inequities, increasing prevention, and enhancing coping abilities are to be met through health promotion mechanisms and implementation strategies defined in the document. The Epp paper assumes that public policy has the authority to provide people with the opportunity for health and also to deny chances to achieve health. The policy areas of income security, employment, education, housing, business, agriculture, transportation, justice and technology are included as influencing health.

Following the Epp document, Health and Welfare Canada (1988) released a second paper designed to increase the understanding of mental health. Historically, mental health has been viewed simply as freedom from psychiatric symptoms or the absence of mental disorder and past definitions have focused on the psychological and behavioural characteristics of individuals rather than on conditions in society as a whole (Health and Welfare, 1988).

The definition of mental health in the document reflects the expansion of the mental health field to include social concerns as well as medical and psychological issues, and prevention and promotion as well as treatment. It acknowledges that the distribution of power among individuals and groups is a crucial determinant of mental health. It also confirms the importance of acting towards individual and collective goals and reaffirms values of justice and equality.

Using the health promotion framework, the document reviews current mental health challenges and potential responses and then outlines seven guiding principles for the development of public policies to support mental health. These principles are: (Health and Welfare, Canada, 1988)

1. Human rights and Citizenship - All Canadians have equal rights to participate in Canadian society, including the right to health and social services, education, employment, housing and recreation, and the right to be protected by the law.
2. Mutual Aid and Voluntary Service - The support and assistance that members of a community freely give to one another is an essential component of mental health promotion and mental health services.
3. Consumer Participation - Mental health services and health promotion activities are strengthened when those whom they are intended to benefit participate in their design and implementation.
4. Professional Participation - The delivery of mental health services and the promotion of mental health are strengthened when professionals bring to these tasks not only their specialized knowledge and skills but also an openness to collaborative approaches, and a breadth of vision concerning the overall needs of individuals and communities.
5. Strengthening Communities - A community's capacity to promote mental health and to provide care for persons with mental disorders or disabilities is strengthened by a balanced allocation of resources, by removing obstacles to community-based programs, and by building consensus regarding the values and strategies that should govern mental health policy.
6. Knowledge Development - Progress in the promotion of mental health and the prevention and treatment of mental disorders depends on increasing, integrating and sharing relevant knowledge from many fields.
7. Policy Coordination - Mental health is a major public health issue that requires coordinated policy and program responses from all sectors of society.

In reading these documents I was troubled with how the concept of control, articulated in the definitions of health and health promotion, was substituted with the concept of participation in the Health and Welfare documents. The definitions of health and health promotion include such terms as "personal choice", "increased control", and "change or cope with the environment". The expectation that achieving health involves a shift in power or control and involves understanding the context of an individual's circumstance is explicit in the definitions. The connection between increasing personal control and increasing personal health is emphasized.

On the other hand, the Health and Welfare documents provided a policy framework that emphasized ensuring effective public participation and fostering community empowerment as strategies integral to the achievement of mental health and the development of healthy public policy. They both acknowledge equalizing power differentials as integral to the process but fall back on "participation" and "empowerment" as the means to achieve a redistribution of power. There is an implicit assumption that participation ensures control and therefore better health. I was left wondering if words like "participation" and "empowerment" mask the struggle for control and if so how a redistribution of power ever occurs. I went to the literature on community and user participation to continue to build my framework.

Community and User Participation

The theoretical literature raises many questions about power, control and participation, confirms that effective implementation of community involvement is elusive, and identifies some difficulties inherent in community participation processes. However, it stops short of an analysis of how participation processes are constructed. As noted previously, increasingly over the last 10 years a commitment to user and community participation has been part of government, professional and organizational policy language. Questions are now professional and organizational policy language. Questions are now emerging in the literature as to why this commitment has not also become a part of government, organizational and professional practice.

Any discussion of "participation" must include an understanding of the terminology being used to describe who is participating. As I explored the participation literature I became more and more aware of "language as the site of the struggle" (Weedon in Church, 1992). The term "consumer" is popularly being used in the mental health field to replace "patient" or "client". There is not overwhelming agreement that this is an appropriate term and as a result both the term "user" and "survivor" are also being introduced to the discourse. The use of the word "consumer" originated in the western industrial nations of Europe, North America, Australia and New Zealand and makes most sense in the context of a highly industrialized production oriented society (WHO, 1989). The term implies a restructuring of relations through user purchasing power but some argue that it carries with it a "false implication that users of mental health services choose the services they receive" (Church and Reville, 1991). Rose and Black (1985) link the use of the term to the commodities market. "There is a striking parallel between consumers of services and consumers of commodities: both are out of control of what they consume; both stand outside the determinants of the process of production; both act in response to a definition of their needs outside their conscious control; and both are passive recipients of the interaction which reproduces existing power relations" (Rose and Black, 1985, pg.37). How does this standpoint on "consumerism" fit with the concept of "participation"? As I examine the language and meanings, I have to wonder if the term "consumer participation" is an oxymoron. How does the word consumer mask power relations?

However, the other terms in popular usage to describe people involved in participation processes also raise questions. The term "survivor" is becoming more popular and appears to be particularly accepted by survivors. It implies strength and coping and health. It is however criticized as confrontational because it contains a political statement about the social and economic conditions of people with chronic mental illness. It also implies that people have "survived' the system in order to cope with their illness. Perhaps the discomfort and tension that the word raises is itself indicative that "survivor" doesn't mask power relations in the same way that "consumer" does.

Other terms such as "community" and "citizen" are much more neutral and broad but again mask power relations. Church and Capponi (1991) argue that people occupy different positions (socially, politically, economically etc.) in the world and these differences are played out in fundamental differences in experiences, their meanings and their consequences. Therefore, when we talk generically about "citizen or community participation" are we diffusing the inevitable tension that arises between people acting from different experiences and standpoints? How do we accomplish participation without addressing these tensions and how does the discourse currently being adopted along with these "new" frameworks contribute to the masking of power relations and ultimately to non-participation? With these questions in mind, I looked at the literature on participation.

Labonte (1989, p. 24) defines community as " the act of people being together". He argues that even though community is often defined by population or by geography (the poor community, the native community, the women's community, the neighbourhood community, the rural community), the concept of community is neither static nor a demographic fact but embodies the quality of sharing and is essentially organization. McKnight (1987) defines community as the social environment or "social place used by family, friends, neighbours, neighbourhood associations, clubs, civic groups, local enterprises, churches, ethnic associations, temples, local unions, local government, and local media"(p.56). He concludes that communities provide a "social tool where <u>consent</u> rather than <u>control</u> is the primary motivation, interdependence fosters holistic environments, people of all capacities are incorporated, quick responses are possible, creativity is multiplied rather than channelled, individualized responses are characteristic, care is able to replace service and citizenship is possible" (McKnight, 1987, p.57. McKnight's definition of community replaces the concept of <u>"community control"</u> with <u>"community consent"</u>. Again, I am struck by how easy it is to dismiss the issue of power and control, even though it is acknowledged throughout the literature, by subtly replacing words.

While McKnight tends to see community and community consent as the panacea for social ills, Labonte (1990) warns against creating an "us/ them" polarity between professionals, institutions and the community. He says this process of polarizing has the potential of disempowering professionals and idealizing communities. He reminds us that communities are complex networks of social interaction, not always healthy or empowering in those interactions. Farrant (1989) agrees and points to the incongruities in assuming communities are homogeneous wholes. When defined in this manner communities are given very little encouragement to analyze power relations within and between each other. She asserts that it is rarely acknowledged in community participation initiatives that as well as consensus and cooperation, conflict and confrontation can be expected. My own experience tells me that, in fact, an implicit expectation of community groups is that they will arrive at decisions and operate without conflict. If community groups do acknowledge and accept conflict and confrontation, there is often a sense of failure with the process. As pointed out by Church's (1991) work, the assumption of homogeneity is reinforced by the language and labels (community member, citizen, consumer) used to describe participants in the community process.

Several authors (Labonte, 1990, Lord, 1989, Farrant, 1989) agree that community involvement rests upon the principle of community self-determination of problems and solutions and that exploring the dilemmas and paradoxes inherent in self-determination needs to be an integral part of the participation process. Community self-determination implies community control to me and I have to assume that the inherent dilemmas and paradoxes referred to are likely related to the struggle for control and the redistribution of power. This again leads me to question how I might conduct my research to discover relations that coordinate acts of participation and acts of self determination or control.

Implicit in the community participation discourse is the necessity for a paradigm shift from professionally driven and defined services to community driven and defined resources, which also necessitates a redistribution of power. Labonte (1990) challenges professionals to think of their role not as "service providers (doing unto others) but as resources essentially allowing people to do unto themselves" (1990. pg. 67). He makes a distinction between resources and services and says ""a resource is something that is used by a subject; a service is something that is delivered to an object" (Labonte, 1990, pg. 67). McKnight (1987) identifies three visions of society that he says dominate the discourse on social policy development. They illuminate the difference in perspectives and are described as: (p.57)

- The therapeutic vision - sees the well-being of individuals as growing from environments composed of professionals and their services. It envisions a world where there is a professional to meet every need, and the fee to secure each professional service is a right.
- The advocacy vision - sees a world in which "labelled" people will be in an environment protected by advocates and advocacy groups. It seeks to protect an individual from an alien community and seeks to insure a person's right to be a functioning individual.
- The community vision - sees a world where "labelled and exiled" individuals are reintegrated into the community. It understands the community as the basic context for enabling people to contribute and sees community relationships as the context to provide opportunities and become the political defenders of the rights of individuals.

Defined this way, the therapeutic and advocacy vision represent professionally defined and driven services and the community vision represents a paradigm of inclusiveness and community defined outcomes. The question remains however what each vision actually looks like in practice. I wonder if there are recognizable differences in practice or do the "vision" statements satisfy our discomfort and mask ongoing embedded practices?

Lord (1989) conceptualizes user participation as the active and equal involvement of users of mental health services in community, provincial and national planning and policy decision-making. He concludes that while this is an ideal to be reached and many health professionals and community members are incorporating the words of participation and involvement in their language, the actual involvement of users in decision-making is extremely limited in Canada. Church and Reville (1989) concur, stating "user involvement in Canadian mental health services is in an embryonic stage and existing initiatives are generally undocumented" (p.22). They make distinctions between three broad categories of user involvement:

1. consumer-controlled activities, which occur when the "structure of an organization ensures that consumers have the power to make binding collective decisions on all issues within the mandate of the organization" (p.23).
2. coalitions and partnerships, which are driven by consumer needs and preferences but involve the support and participation of the wider community, service agencies, funding bodies etc.
3. consumer participation, which gives users the opportunity to influence decisions and actions which affect them without ensuring consumer control.

Again, it is clear that the distinctions made by Church and Reville are based on the differences between control and participation. Significantly though, instead of redefining control as participation or consent, Church and Reville make clear distinctions and retain the concepts and the different elements they contain.

Valentine and Capponi (1989) say that user participation on boards and committees has become the "in" phrase in mental health services but effective implementation is elusive. They identify six interrelated barriers to effective user participation:

1. Incongruity between stated organizational values and actual practice.
2. Tokenism - This refers to both the number of consumer representatives and the level of responsibility assigned.
3. Lack of representativeness - Users are far from being homogeneous and representation does not necessarily ensure that differing views are represented (representativeness).
4. Role Strain - Roles and functions may be unclear and differ significantly from traditional roles of "professional" or "helper" and "community or "client".
5. Poor communication
6. Economic factors - professionals may be compensated for their time and expenses incurred when doing committee work. Users and community members usually are expected to volunteer and do not receive compensation and such things as transportation, child care, food expenses may prevent some people from participating.

While there is little documented about user involvement in mental health services, there is even less about broad based community involvement in planning for mental health services. Boudreau (1991) examines the concept of partnership as the new strategy in mental health policy in Quebec and argues that governing bodies have "elevated partnership from its basic roots in local neighbourhood support ideology to partnership as the conceptual base for broader province-wide policy-making" (p.315). She proposes that the concept of partnership promises solutions to governments' key strategic problems, defined by her as:

1. the exhaustion of resources and allocation of losses.
2. the loss of faith in government and the consequent need to redefine the role of the state.
3. the loss of faith in professional knowledge and the increasingly forceful voice of alternative and "psychiatric survivor" groups.
4. the problem of overload and the search for consensus and frictionless solutions.

Through identifying the problems facing government that the concept of partnership appears to address, Boudreau may be getting close to the "real" purpose of community participation or the "something else" that I have identified as problematic. Several others (Reville, 1987, Pascal, 1991, Labonte, 1990, Farrant, 1989, Rochefort, 1991) question the intent of community participation rhetoric and advocate for the careful examination of the implementation of these initiatives.

The literature theorizing community participation points to unanimous agreement regarding the important implications of power and control in community processes at the same time as it is contradictory. On the one hand, there is overwhelming support to the notion that power relations and issues of control and self determination are integral to understanding and implementing community participation processes. On the other hand, there are several instances of contradictions in the literature and obvious areas where language mystifies or masks explicit references to power and control issues. The quest for explication of these contradictions led me to the literature on power and empowerment.

Power and Empowerment

Power is defined in the literature in various ways and is a multi-faceted entity. However, central to most definitions is the concept of being able to exercise control over one's situation or life (Labonte, 1990, Lord & Farlow, 1990, Pinderhughes, 1983, Church and Reville, 1988). Boucher (1992) describes two differing conceptualizations of power. The first she calls "power over" which has been influenced by the mechanistic world view that sees power as static and of limited quantity which is distributed unevenly to isolated individuals or groups. The second is a more dynamic and dialectical (ie. a two-way developing relationship) understanding of power that focuses on the connections or relationships between the individuals involved. Within this understanding, Boucher (1992) argues that the effectiveness of the exercise of power depends on the nature of the relationship through which it flows. Iannello (1992) conceptualizes power as the ability to accomplish goals rather than domination or control over someone or something.

However, despite the attempts of feminists and writers from other critical perspectives to bring the dynamic understanding of power into the mainstream, asymmetrical power continues to permeate human services. Labonte, citing Morgan (1986) says that power "exists principally in our social relationships as asymmetrical patterns of dependency whereby one person..... becomes dependent on another in an unbalanced way..... Professionals continue to have the power to define and name other people's problems and solutions (Labonte, 1990, Lord & Farlow, 1990, McKnight, 1987, Cochran, 1990). These views and conceptual ideas about power challenged me to begin to question how power relations develop.

Church and Reville (1989) assert that user involvement in mental health services is an issue of power imbalances and the discomfort equalizing power brings to bear on systems. People prefer to talk about service or service delivery, terms that tend to mask the power relationships inherent in systems and organizations (Church & Reville, 1989). There is agreement that within our current structures "caregivers" are given little opportunity to examine and understand how the power relations are masked by "helping", "caring" or "service" terminology (Church, 1989, Lord & Farlow, 1990, Labonte, 1991, McKnight, 1987). While the dominant group (professionals, service providers, policy makers) may be unaware of the power relations, recipients of services are very sensitive to power issues. Although they may not be able to name their experience as a power imbalance they are sensitized because they have experienced powerlessness and alienation within the mental health system and feel it as a negative experience (Church & Reville, 1989).

Several writers attempt to identify the reasons for power imbalances. Lord (1989) identifies paternalism, the medical model and the professionalization of mental health services as the social and historical reasons that have contributed to keeping users and communities in the "client" role and out of the decision-making role. Valentine and Copponi (1989) agree and add that these factors are pervasive, particularly in institutions where "clients' are rendered dependent and vulnerable and staff become "systemized" and internalize attitudes and approaches that keep clients out of the decision-making role. From this description, it is interesting to note how the language used to explain power relations serves to mask the actors, the relationships of real people and the process through which power is enacted.

McKnight (1987) sees society today as the site of a struggle between community and institutions. He argues that many within service systems and institutions believe they are in direct competition with communities for the power to correctly define problems, provide scientific solutions and professional services. Again, this represents the mechanistic view of power that sees it as static and of limited quantity. This argument is devoid of actors or their relationships and the debate takes place using abstract concepts of community and institution. McKnight goes on to argue that when service systems and institutions have this power to name, the social networking and care in community is replaced by the service of systems and the citizens of community become clients and consumers of institutional products. In other words, relationships are replaced by institutional power. How is institutional power constructed? How does this view of power serve to render people invisible? McKnight argues that when this happens the flow of authority, resources, skills, dollars and legitimacy is removed from community control and given to service systems and institutions. He also says this power struggle is never carried out in the abstract but occurs every day in the relations of people, the budget decisions of systems and the public portraits of the media (McKnight, 1987). McKnight's work further helped me understand that power is not an abstract concept but has a definite material base, has real effects on real people and is somehow related to state funding and control. How this happens remains an unanswered question that is crucial to my study. His work also helped me see that I needed to examine the everyday practices and lives of people in systems to uncover concrete connections between state funded mental health services, community control and professional and bureaucratic practices.

Farrant (1989) contends that interest in community development in the U.K has not translated into a devolution of power in decision-making, but rather it has become the arena for power struggles between different professional groups and statutory sectors for resources and professional control. She provides evidence of another power struggle, this time defined by the abstract concepts of institution and professionalism but still devoid of how the struggle occurs in the everyday relations of people. Further, she argues that activities in the U.K continue to be professionally controlled and community involvement often amounts to community manipulation. "Health professionals are adopting the language of community development without taking on board the fundamental principle of community control over the definition of health needs and solutions" (Farrant, 1989, p.4). She argues that if the potential of community involvement to challenge rather than reinforce power relations is to be realized, a critical and historical analysis of the relationships of power and control embedded in the different approaches to community involvement needs to be carried out. And I add, perhaps more importantly, the power relations embedded in and reinforced through professional training and practice need to be critically examined. It would appear that "power" is still being practiced by professionals and an examination of community participation needs to pay attention to professional practice and how power is enacted through the professional relationship or expert role.

In response to a need to explore how those with less power might gain power, "empowerment" is another word that is prominent in the discourse regarding community and user involvement in decision-making. Lord & Farlow (1990) say that not only are we still struggling with a common understanding of the concept, but also with a common understanding of the facilitation of an empowering practice. I cannot help but think that this struggle is not surprising because theorizing about empowerment is a response to theorizing about another concept (power) that we are also struggling to understand and appear to work very hard to mask.

The concept of empowerment is based on a fundamental belief that issues of power, control and powerlessness are integral to human experience and societal development and there is an inequitable distribution of power within society (Gutierrez, 1990, Wallerstein & Bernstein, 1988, Lord & Farlow, 1990). The stated goal of empowerment in all of the literature is for the disempowered to attain control, both personally and collectively, over decisions and resources (Cochran, 1990, Lord & Farlow, 1990, Gutteriez, 1990, Wallerstein & Bernstein, 1988, Gibson, 1991).

Another fundamental belief underlying the concept of empowerment is that all individuals and communities have strengths and the capacity to make decisions for themselves, although they may need resources and information to do so (Cochran, 1990, Gutierrez, 1990, Gibson, 1991, Lord & Farlow, 1990). Therefore, conceptualizations about empowerment focus on solutions rather than problems and address people's strengths, rights and abilities rather than their deficits and needs (Gibson, 1991).

There is also much theorizing in the literature about how professionals might "act" in an empowering way. Professionals cannot empower people. However they can provide resources, information and a relationship that is built on trust, collaboration and shared power. An empowering relationship presumes that the professional does not hold the answer for people but rather that in the context of support and collaboration people will develop the insights, skills and action necessary to empower themselves (Gibson, 1991, Gutierrez, 1990, Wallerstein & Bernstein, 1988, Lord & Farlow, 1990, Pinderhughes, 1983). If the professional's attitude is one of "knowing best", dependency is likely to be fostered and the result is disempowerment of people. This is a critical component and one that goes against much of a professional's prior training and socialization. Theorists conclude that in order to create an empowering practice, the professional must begin with a personal, professional and organizational assessment of his/her ability to function within a framework that assumes a critical analysis of the social distribution of power (Labonte, 1990, Maglacas, 1988, Gibson, 1991, Lord & Farlow, 1990, Hegar & Hunzeker, 1988).

Although there is agreement in the literature about this conceptualization of an empowering practice, finding an organization that has a practice framework that assumes a critical analysis of the social distribution of power may be difficult. Reflecting back on McKnight's (1987) work, I question again where and how power and consequently empowerment arises and the real effects it has on real people. In the same way that power is not an abstract concept but materializes in daily practices, decisions and experiences, neither is empowerment and it too is lived out in the day to day experiences of people and in the apparent unrelated decisions that are made daily within organizations. If power is somehow related to state-funded and state-controlled services, how the concept of empowerment is related and what empowerment looks like in practice also seem critical to my study.

The use of empowerment principles in practice in "grass roots" community initiatives (Labonte, 1990, Cochran, 1990, Gutierrez, 1990) is well documented and the literature about empowerment is based on these experiences. However, the concept of empowerment, through implementation of "community participation", has moved into public policy and government directives. Therefore, also integral to my study is how an empowering practice takes shape within a large publicly-funded and state-controlled organization? Again, I saw that I needed to examine the everyday practices and experiences of people to discover the linkages between empowerment practices, community participation and publicly funded and controlled services.

The empowerment of communities is referred to in the literature as the collective result of personal empowerment and in some cases empowerment is defined as a collective process only, without making the distinction of personal empowerment. There is an assumption that when people who feel personally empowered come together in a common effort, community empowerment follows. McMurray (1991) states that "when a community is able to choose strategies for health based on appropriate information, local resources, accessible support and institutional, organizational and social approval it can be described as empowered" (p.19) and that this concept of community self-determination is central to achieving health for all. There is absolutely no disagreement in the literature about this link between having control and the achievement of health. However, making the leap from current government practices of withholding information and centralized control to environments where communities can choose strategies remains largely unexamined. Beaudreau's examination of the concept of partnership in Quebec is one example of beginning this analysis. She concludes that while proposing stakeholders become partners, Quebec mental health policy has not yet "sufficiently changed either the rules of the game or the structural constraints that exist at all levels" (1991, p.325).

Iannello (1992) relates the concept of empowerment to decision-making and management of organizations. She suggests power in organizations is associated with the notion of controlling others and empowerment is associated with the notion of controlling oneself. Therefore, she argues, in organizations operating from an empowerment framework, workers would monitor themselves, whereas organizations based on power require administrative management and control functions (Iannello, 1992). In order to monitor themselves workers in the organization have to gain, regain or have enough power to have the ability to control themselves. However, Iannello's analysis again leads to the question of where and how power or empowerment arises from within organizations.

While the literature on empowerment is useful to my study, the application of empowerment principles in practice in the larger context of governmental and organizational policy and practice is very limited. Can the concept or ideology of empowerment be put into practice in large bureaucratic structures such as the Ministry of Health? What does organizational use of empowerment look like?

Several writers' work tell me that power and empowerment arise not from abstract theoretical concepts but from the everyday relations of people organized in certain ways. Power as domination, power as control, power as relationships all seemed to me to be incomplete conceptual explanations. I began to see power and empowerment as complex webs of interrelated connections that defy either/or or cause and effect arguments. I began to see power and empowerment as social relations.

Social Relations

Smith (1987) defines social relations as 'concerted sequences or courses of social action implicating more than one individual whose participants are not necessarily present or known to one another" (p.155). Social relations consist of not only the ongoing activities of individuals but also the circumstances in which these acting individuals find themselves (Jackson, 1984). Social relations are not necessarily bounded by the setting in which people's everyday lives are lived. For example, in her study of an employment agency, Ng (1988) found that the act of counselling immigrant women did not begin and end in the agency but was part of a set of social relations which had to do with the way in which the state attempted to regulate and rationalize the "production" of immigrant women for the labour force by contracting out some of its functions to community groups with closer "grass roots" affiliations. Jackson (1984) and Ng (1988) agree that even though social relations organize actions, they are often obscured by a variety of ideological processes and rendered invisible. Social relations within organizations are almost always determined by circumstances outside the immediate experience of the individual or groups of individuals

(Jackson, 1984). Therefore, the interactions within a structure cannot be understood without reference to the context (political, administrative, economic, historical) within which it is situated (Ng, 1988, Campbell, 1988, 1992).

Smith (1987) argues that much of how we construct or perceive people's actual experience within organizations does not represent their naturally existing world but is "the artful construction of text-based methodologies and the practices of formal organizations" (p.153). People's naturally existing experiences are transformed through the objective practices of formal organizations, information systems and record keeping in various spheres. These administrative, management and professional spheres are interwoven together through social relations into what Smith calls an apparatus. Further, Smith (1987) says this apparatus performs a work of ruling. Therefore, the construction of ideological understandings of one's experience is particularly damaging to those with little or no power in society because it is based on the relations of the ruling apparatus.

Smith (1987) advocates that the study of social organization needs to "explicate the actual social processes and practices organizing people's everyday experience from a standpoint in the everyday world" (p.151). The exploration of how people's actual experiences in their everyday life are organized as a complex of social relations beyond any one individual experience uncovers that which is often invisible to those living the experience. Although Smith advocates for the activities of people in their everyday world as the beginning point for examining social relations, she also says that social organization is only partially discoverable within the scope of an individual's daily activities. The local organization of individual experience "is determined by the social relations of an immensely complex division of labour knitting local lives and local settings to national, and international social, economic, and political processes" (Smith 1987, p.154) that she calls "ruling relations".

The question then is how social, power or ruling relations become organized within publicly funded organizations. The "rule of law" is the motivating force around which public service organizations are organized. Rules are articulated in legislation which then becomes the basis for policy. When operationalized into practice these rules become connected to services and over time, given the use of specific kinds of organizational practices, services become subjected to logical and objective control. As Ng (1988) concludes in her study of a community-based employment agency, this objective control then has the potential to structure the work process of organizations, the output of work and the social relations within organization.

Within the context of community participation in policy development, Smith might argue that it is likely that the construction of community participation is built on how social relations organize the everyday world of community members and recipients of mental health services. Furthermore, an awareness of how social and power relations organize their experience of participation may be invisible to community members. I began to see that I needed to discover how or through what practices relations are organized to accomplish adherence to the "rule of law" in a public service organization? This led me to look at professional and bureaucratic practices and to the literature on organization and bureaucracy.

Organizational Theory and Practice

The field of organizational analysis has historically been polarized into the mechanistic school of organizational theory and the human relations school (Perrow, 1982, Iannello, 1992, Drucker, 1974). Simply put, the mechanistic view treats organizations like machines and is dominated by rational theory that emphasizes routine methods, logic in planning and the suppression of the "irrational" tendencies of workers (Perrow, 1982, Iannello, 1992).

Some theorists of the mechanistic school stress the importance of communication and information within organizations, but continue to rely on the rational planning methods to direct the organization and design and operate the administrative machinery necessary to achieve the goal (Iannello, 1992).

The human relations school, emphasizes people and explores what have been seen as the "irrational" elements of human nature, conceptualized as "informal" as distinct from "formal" organization. Informal organization is described as the everyday, unofficial relationships among workers and the unwritten rules, attitudes and behaviours that influenced the productivity and environment of workers. An outcome of this school of thought was the development of participatory management with an emphasis on worker input (Iannello, 1992). Although introduced years ago, the concept of participatory management has been undergoing a re-emergence in the last 5 to 10 years.

As a result of critical views and the recognition that power and conflict were not only rampant in organizations but also functional, another school of thought, known as the open systems model, emerged. Theorists in this group focus on the relationship between the organization and the environment and consider the influence of the values, norms and ideologies of society on the goals, structure and operations of organizations (Perrow, 1982, Iannello, 1992).

Integral to a discussion of organizational theory and practice is an understanding of the term bureaucracy. Scott (pg. 24) defines bureaucracy as the "existence of some kind of specialized administrative staff." Iannello (1992) argues that hierarchy, around which channels of authority, systems of communication and performance guidelines have developed, is the key component of bureaucracy. She argues that even though the theoretical base for each school of organizational theory is different, the practices within each do not stray from the dominant belief that hierarchy is needed to accomplish organizational goals, nor do the practices do anything to alter the distinction between the managerial/rational class and the worker/irrational class within organizations. Iannello (1992) attributes this dominant view of organizations to the work of Robert [Michels in 1911 and his "iron law of oligarchy". Michels "law" describes oligarchy as inherent in or synonymous with organization and for that matter human nature. His research rejects the possibility of egalitarian organization and provides the basis for widely held beliefs in organizations today about special interests and the need for a ruling elite (managers) who have superior knowledge and information in order to make decisions to attain goals.] Although Michels's work has been criticized, the premise of his work is the dominant perspective of organizational theory and other "critical" perspectives have not been as widely recognized. Iannello (1992) argues that, as a result, hierarchy remains the unquestioned structural characteristic of organization regardless of the particular school of thought.

The contribution of feminists scholars and those from other critical perspectives to this body of organizational literature has allowed for the study of the impact of societal values on organizations. This has resulted in an analysis of the concept of power, control and domination in organizations as well as a critique of embedded assumptions about hierarchy and the link between bureaucratic practices and the capitalist economy. Domination as it is fostered by patriarchy in organizations is being explored and characteristics of workers previously viewed as irrational or idiosyncratic are being recognized as representing the multiplicity of standpoints inherent in an organization.

Ferguson (1984) critiques bureaucracy from a feminist perspective and stresses that bureaucracy must be considered in the societal context which it resides. She sees the context as one of fundamental inequities between class, sex and race and labels bureaucracy "the scientific organization of inequality" (pg. 8) that serves to project domination into an arena that rationalizes and maintains inequity and the dominant perspective.

Franklin (1992) explores the modern technologies of management and government. As noted in Chapter 1, I am using the term technology, as Franklin does, to describe practice or ways of doing something. She says that technology has "acted to reorder and restructure social relations, not only affecting the relations between social groups, but also the relations between nations and individuals, and between all of us and our environment" (Franklin, 1992, pg. 13). She makes a distinction between work-related technologies that make actual practice easier and control-related technologies that try to increase control over the work process. She uses the example of the change from a mechanical typewriter to a word processor. The use of an individual word processor is a work-related technology that makes the practice easier. When the word processor is linked to a work station or system it becomes a control-related technology where worker's time can be monitored, assignments can be broken up and interaction between workers can be monitored. Further, she looks at how work is actually being done and makes a distinction between "holistic" and "prescriptive" technologies. The former are work processes where the individual worker is in control of the particular process from beginning to end. Holistic technologies are normally associated with the notion of craft where the worker makes decisions on the process of the work as the situation arises. This ability to make decisions and use judgement in the work process is very important to the outcome. People work together and share ideas and experiences but the way in which they work together leaves the individual worker in control of how something is created or done. On the other hand, prescriptive technologies rely on breaking the work process down into clearly identifiable steps and each step is carried out by a separate worker or group of workers. When work is organized in this way the control over the work moves to the organizer or manager and the occasions for decision-making and judgement by individual workers are eliminated. Franklin (1992) argues that prescriptive technologies have gradually replaced holistic technologies since the Industrial Revolution and are not restricted to materials production but are used in administrative and governance activities. While recognizing that prescriptive technologies are highly efficient and effective in some environments she points out that their use and acceptance without question comes with a very high social cost. She argues that prescriptive technologies are "designs for compliance" and "when working with such designs, a 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, 1992, pg. 23). Franklin also links prescriptive technologies to social relations when she says that "technology becomes an agent for ordering and structuring. The ordering that prescriptive technologies have caused has now moved from ordering <u>at work</u> and the ordering <u>of work</u>, to the prescriptive <u>ordering of people</u> in a wide variety of social situations" (Franklin, 1992, pg. 25). This ordering is also an agent for power and Franklin's work points out how the distribution of power and control is structured through the design of the technology. Franklin (1992) also argues that "any task that requires 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 can be" (Franklin, 1992, pg. 24). In relation to my study, this led me to question whether community participation, empowerment and decision-making required immediate feedback and adjustment and how publicly-funded government bureaucracies, where work is predominantly managed through prescriptive technologies, impacted on or "ordered" the experience of the people and affected their ability to gain power and be involved in decision-making.

Campbell (1992) notes that Weber's analysis of bureaucratic administration has been extended by Dorothy Smith to include an examination of the textual nature of the exercise of power and control in organizations. Texts are conceptual practices of ruling, where actual experience is objectified and rationalized through documentation in order to accomplish the operationalization of the "rule of law". Smith (1984) argues that in the ongoing quest for efficiency and with the advent of increased technology, knowledge of what workers actually do is translated into objective information that can be talked about and supposedly understood from another location in the organization. This reporting and record keeping creates a standard set of meanings that are used to support and augment other organizational data but misrepresent and reorder workers' actual experience. In this way, the reporting and record keeping practices actually accomplish the ruling through decision-making as a centralized function, no matter where the "policy" ideas came from. Campbell's (1992) study of child protection workers and an attempt to implement workload measurement technology is an example of this exercise of control in organizations. She concludes that as new ruling practices spread into human service intervention, workers are trained to interact differently and in this case more impersonally, regardless of their personal attitudes and intent.

The literature on organizational theory and practice illuminates the various management technologies through which power, control or ruling are exercised or exerted within organizations. These technologies include relational practices of ruling as well as structures that ensure power and control mechanisms. Bureaucracies, of which hierarchy is a major component, are examples of structural mechanisms and newer technologies or ruling practices such as information-based decision processes are examples of how control is accomplished in organizations through ruling relations. The contradictions between the concepts, structures and practices that support control mechanisms (ruling practices) within organizations and the concepts of inclusion and community participation (empowering practices) were illuminated throughout this examination of the literature. Of critical importance to my study is that [ruling practices appear to have the effect of shaping the best intentions of people within the systems. How might this "shaping" or "social relations" effect the best intentions of professionals to operate in a way that creates an environment for the empowerment of consumers] and citizens?

Review Of Research Studies

There is agreement in the literature that empirical knowledge about community and user involvement in policy development is limited and that there is little in current research to explain the process whereby people move from being dependent and powerless to feeling a sense of control and participatory competence (Lord & Farlow, 1990, Church & Reville, 1990). The area of mental health is perhaps the most advanced in this regard due in large part to the involvement of its voluntary sector and self-help movement (Church & Reville, 1989).

In their study of personal empowerment, Lord & Farlow (1990) interviewed a number of key informants and conducted 38 in-depth biographical interviews with people who had directly experienced the process of gaining more control in their lives. While they were specifically studying the process of personal empowerment, defined as "the process whereby the individual feels increasingly in control of their own lives" (Lord & Farlow, 1990, pg. 3), their conclusions indicate that the personal is connected to the collective. They found a direct positive correlation between the interviewees' prolonged dependency on services and their feeling of powerlessness, and a positive relationship between participation and personal empowerment. The process of participation was both empowering and self-reinforcing. In addition, informants reported repeatedly that there is a wide gap between the language and reality of participation.

Church and Reville (1990) documented the process of user involvement in a mental health consultation process in Ontario by conducting sixty telephone interviews with key informants and by attending the consultation meetings. The major difficulties with the consultation process revealed by the study were:

1. Time frames were too short to give people time to participate.
2. Barriers to participation, such as literacy, poverty, transportation, child care were not systematically and proactively broken down.
3. The discussion paper prepared by government for the consultation process did not frame the legislative issues so that consumers/survivors could address them.
4. The consultation meeting environment was unfamiliar to consumers and therefore alienating.
5. The consultation meeting process was formal and intimidating to consumers.

As a consequence of observing two consultation meetings, the researchers formulated plans to conduct an alternate consultation process. They met with consumers in small groups in places that were familiar to them and allowed them to frame the discussion. Participants didn't want to provide input into the issues as they were framed in the discussion paper but were willing to discuss their lives. The issues raised by life experiences framed the discussions very differently than the consultation meetings that reflected what was relevant to policy makers and service providers, although presumably both might have been spoken of as "empowerment", depending on the standpoint of the speaker.

Farrant and Russell's (1988) case study of the production of a health education booklet is interesting to note because of the community input process into the production of the booklet. They found that the process was predominantly controlled by the professional community. Consultation was engaged in when the booklet was near completion and few changes were possible. However, in doing the consultation, Farrant & Russell found that the community consulted was well aware of the contradictions in the message that the booklet was delivering. Local readers "saw through" the text and discerned the complexity of the issues even though they were not reflected in the booklet. Farrant and Russell attribute the general public's ability to "see through" the message in the booklet to what they "knew" from their life experiences. They knew there was not a consensus in the medical profession about Congestive Heart Disease and were suspicious of a booklet that claimed that there was. So in fact, the very issue that the professional community tried so desperately to keep invisible, appeared to be common knowledge in the everyday lives of the community members. Farrant and Russell conclude that the end result is that the community sees the professional's message as patronizing and prescriptive, rejects it, and becomes distrustful and cynical about such processes.

The results of these studies continued to illuminate the need for an understanding of the empowerment process and participation with regard to government organization and publicly-funded initiatives. Both Church and Reville's and Farrant and Russell's work are situated in government and professionally driven organizational contexts and point to the disjuncture between the ideological construction of experience and the lived experience of participants in the process. None of these studies, however, indicate an awareness of how social and power relations organize the experience of participation. As pointed out earlier, this connection may be invisible to community members. I would add that it also appears to be invisible in the theory and research on the subject of participation and empowerment.

Review Of Methodological Literature

Church and Reville (1989) attribute the shortage of empirical studies related to consumer and community involvement in part to the limitations of traditional research methods and to the academic community's apparent unwillingness to accommodate itself to the multidimensional dynamic processes of community involvement. However, they note optimistically an emerging trend of participatory research methods being used by mental health researchers across Canada.

Hancock and Draper (1989) conclude that to move from rhetoric to action in health promotion and community empowerment a "new" form of research needs to be practiced. In order to be congruent with the values underlying these concepts, this research must serve to activate, mobilize and empower people, transfer skills and resources to people, ensure that research is in the service of the community and use a deliberate political and community action strategy. They endorse participatory research as the appropriate "new" form and see this methodology as fundamental to health promotion whether it is being undertaken at the personal, community or policy level (pg.2). In advocating for this methodology, the authors acknowledge a number of inherent conflicts and contradictions. Such research approaches are just beginning to become legitimated and accepted and therefore both funding and opportunities for publication in mainstream journals may be limited (pg.2). This creates a conflict between realizing the simultaneous objectives of knowledge development and community empowerment and creates a world for the researcher that is contradictory. At the same time as researchers struggle to be congruent and put community empowerment principles into practice, they are expected to operate within the constraints of the traditional research and academic establishment (pg.2). However, the authors contend that if the movement to health promotion and community empowerment is to be realized these barriers must be dealt with in order for the practice of research to be congruent with the principles espoused by the rhetoric (pg.4).

Lord (1987) supports qualitative methodology, because it is naturalistic, holistic and acknowledges the subjectivity of human behaviour as a means to understand the needs of users of mental health services. Citing his study of users across Canada, he concludes that these methods seek to understand the reality of people's lives, allow for multiple realities to surface and therefore frame problems and solutions differently and some might argue more accurately than traditional methods (pg. 34).

One such method of data collection and analysis that explicates and investigates how the everyday world actually is and how "it" actually works is what Smith (1987) calls institutional ethnography. It is a method that explores the talk and practices of individual actors and uses these experiences as an entry point to examine the larger social processes and identify the complex set of relations that form the ruling apparatus (Smith, 1987, Campbell & Jackson, 1992). Within the context of institutional ethnography, G. Smith (1990) describes social relations as a research technique for examining how individuals organize themselves in relation to others. Social relations are not only something to be examined in research but are also used to do the examining. An analysis of social relations assists the researcher to examine how "people's activities are reflexively/recursively knitted together in particular forms of social organization" (p.636). In this view, the activities of all of the people involved are not isolated and random but rather are organized around various functions - health care, mental health services, education, social welfare etc. D. Smith (1987) refers to the complex set of relations around various functions as the coordinating or ruling apparatus. She argues that institutional relations determine everyday worlds and the local organization of actual lived experience can be studied to uncover the invisible relations that organize our lives.]

In my study I want to discover how people's actions are coordinated or "knitted together" to enact power and control in a participatory process. I will be using the notion of social relations to examine the actions of community members, users of publicly-funded services, professionals, such as myself, charged with "facilitating" the process and professionals charged with managing services and public money. My study begins from accounts of actual experiences of community members trying to become involved in decision-making. I use these accounts as the entry points to understand the previously invisible ruling apparatus and set of relations that organize local experiences.

This is the conceptual framework which guides my exploration of "participation", "empowerment" and "community-based decision-making" within a publicly-funded government contracted initiative and through which I put forward my methodology and analysis

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Chapter 3

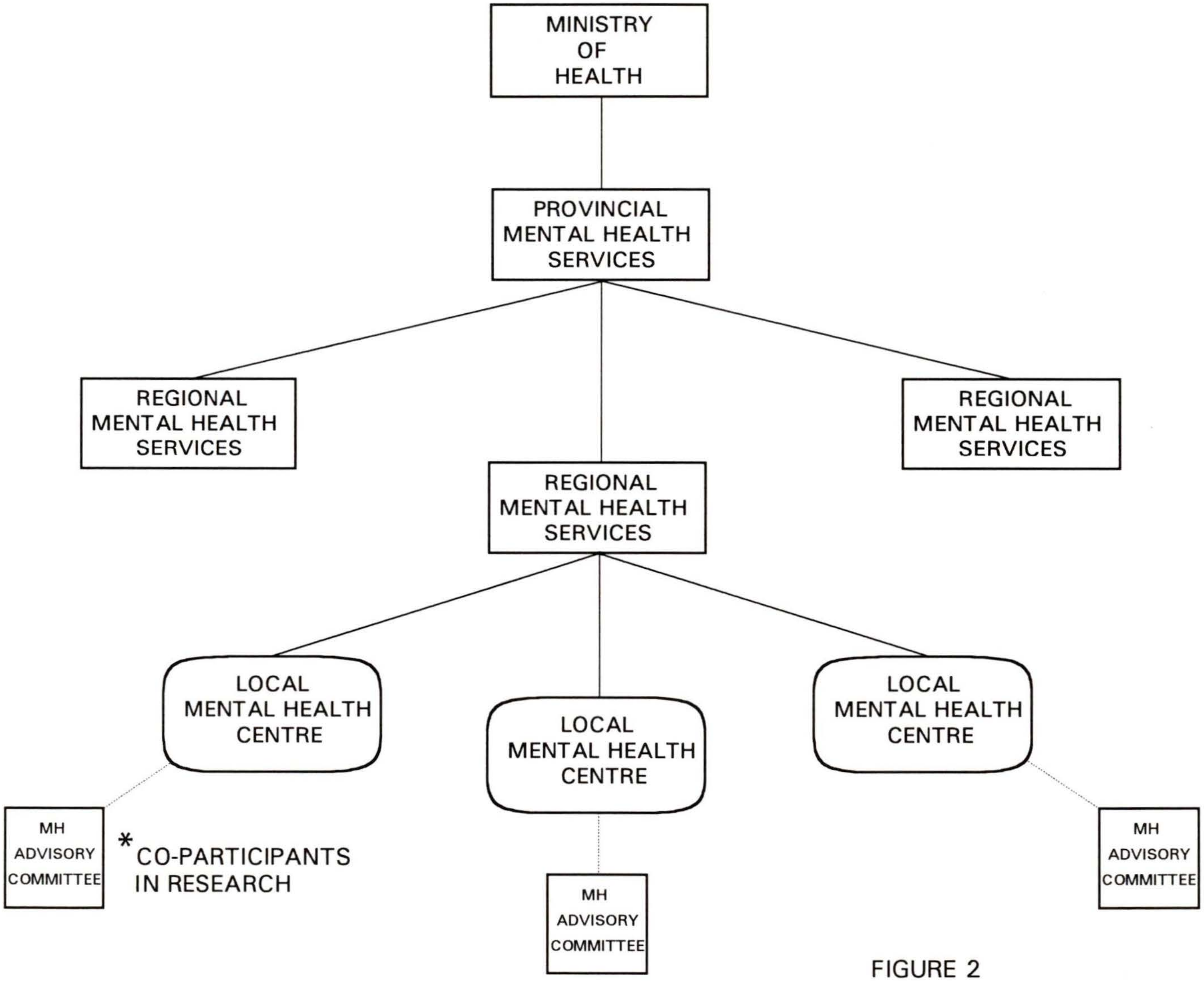
Methodology

The interpretive paradigm stands on the "fundamental premise that the social world has no existence independent of the activities and understandings of the people who participate in it, including the understanding and activities of the researcher" (Jackson, 1991, pg.1). This fundamental premise is the basis for the research methods used for my study and it shaped and guided both the research process and my actions as a researcher. Within the interpretive paradigm, I chose to combine institutional ethnography and participatory methods.

Within a participatory action methodology the researcher and the participants collectively investigate an agreed upon question in order to be able to understand it and act to change it or create something new. The process is three-fold and cyclical; (1) collective problem-posing and investigation (2) collective analysis of the problem (3) taking collective action designed to address the problem (Maguire, 1987). I saw this methodology as providing an opportunity to be congruent with the principles underlying health promotion and community empowerment by developing the knowledge from the standpoint of and predominantly for those with less power in these processes. In addition, participants in the advisory committee had expressed an interest in understanding their experience in order to increase their ability to be part of decision-making.

Institutional ethnography provides a method of investigation and analysis that maintains the primary importance of the participants' everyday experience and also provides a basis for an understanding of the social matrices of that experience. Again, this method is congruent with the principles of health promotion and community empowerment. Rather than testing a hypothesis, it builds a knowledge about how the relations or interactions "work" within the process. Unlike traditional ethnographic research where the organization or setting being studied is examined as a self-contained unit, this line of inquiry seeks to understand the dynamics of a situation or experience by analyzing it within the larger organizational and policy context within which it exists. Thus, as well as seeking to understand people's experience of participation, I attempted to discover the linkages between people's experience and the context of the experience. My own participation in the process was central to the analysis of the participatory process. It was through the reflexivity of my participation and discussions with the participants in my study that I was able to understand the complex set of institutional relations of which our experiences are a part. Maguire (1987) suggests that without close interpersonal interchange and relationships, researchers will find it impossible to gain meaningful insights into human interaction or to understand the meaning people give to their own behaviour. Therefore, it is my involvement and interactions with the participants in the research that ensures the credibility and validity of the study. Without this involvement, the experiences and interactions of the participants may not be accurately described and identified.

At the time of my research, I was employed at a local social planning agency to facilitate the development of mental health advisory committees. I had been hired to work with a broad-based community group to establish a structure to achieve community involvement in the planning and delivery of mental health services in the local area. Figure 2 is a diagrammatic representation of how the advisory committee I worked with fits into the organization of health care services.



MINISTRY OF HEALTH
PROVINCIAL MENTAL HEALTH SERVICES
REGIONAL MENTAL HEALTH SERVICES
REGIONAL MENTAL HEALTH SERVICES
REGIONAL MENTAL HEALTH SERVICES
LOCAL MENTAL HEALTH CENTRE
LOCAL MENTAL HEALTH CENTRE
LOCAL MENTAL HEALTH CENTRE
MH ADVISORY COMMITTEE
*CO-PARTICIPANTS IN RESEARCH
MH ADVISORY COMMITTEE
MH ADVISORY COMMITTEE

FIGURE 2

In effect, while participating in the creation of a structure for participation, the advisory committee members were concurrently involved in a community participation and decision-making process. An integral part of my facilitation of the development of the advisory committee was an analysis of the participants' experience in relation to the larger organizational context. The research became a tool for the group's understanding of participation and involvement in decision-making and complemented my work as a facilitator.

Participants

I use the term "participant" rather than "subject" to apply to those involved in the study because rather than being treated as passive objects under investigation, they were active in the research process and in fact might be considered co-researchers.

I worked in a participatory way with one advisory committee and began by securing permission from the social planning agency to engage the advisory committee in a discussion of the possibility of doing this research simultaneously with the facilitation of the advisory committee's development. I attended a meeting of the advisory committee with an explanation of my research (Appendix A) and asked if they were interested in examining with me the policy development process we were participating in. I received permission from the group and then informed both the Ministry of Health and the emerging Regional Health Board in the local area of my research activities. I received overwhelming support and interest in this research.

The members of the mental health advisory committee who participated in this study had organized before there was formal support to the process and the group was fairly well developed when I began to work with them in April 1992. At that time the committee had been meeting for approximately 18 months.

The core committee consisted of:

two parents of adults with chronic mental illness
two people with chronic mental illness
a local physician
director of a local family counselling agency
director of a local crisis and referral centre
director of the local mental health centre
a front line staff person from the mental health centre
representative from the local school district
myself from the facilitating agency.

This committee was considered to be broad-based community group although a balance of professionals, citizens, consumers and family members was never achieved. The committee had not been selected or appointed by professional staff but self selected from interested people. The membership was open and new members were added as people expressed an interest or as needs arose and creating a balanced membership was continually being attempted. Community in this case was defined both by issue (mental health) and geography. Each one of the members participated in other community groups and served as liaison to the other groups thereby broadening involvement.

Data Collection And Analysis

The data for this study were obtained primarily from my fieldwork with the mental health advisory committee from March 1992 to February 1993. The principal data collection strategy I employed was participant observation. I tape recorded all meetings of the advisory committee and observed and kept fieldnotes of the mental health community development activities that I was involved in. This included management planning meetings, meetings of the developing Regional Health Board, open public forums, meetings with the advisory committee and informal conversations with many people involved in the process. As well, I kept a personal journal of my experience. As the research process unfolded, I found I wanted to understand more fully the experience of a consumer and a family member so I conducted two in-depth interviews, one with a consumer and one with a family member who were members of the advisory committee. Individual consents (appendix B) were obtained from them. Interview and meeting tapes were transcribed and transcriptions were given back to participants for verification. In addition, I had access to a variety of documentary materials, including reports, minutes, agendas, historical documents, contracts, funding criteria and proposals, and budgetary material.

The process of data collection and data analysis occurred simultaneously and reflexively. As I collected data and wrote my fieldnotes, I continually referred back to my conceptual framework and began to formulate my analysis. That analysis then informed more questions and I would search out different documents or people to answer those questions. I met regularly with the advisory committee and when we discussed the process they always had ideas that enhanced the analysis and challenged me to continue to look in another way at "how" the process was working. Therefore, throughout the data collection and analysis process, I was continually verifying my analysis by ensuring that the participants recognized the findings as an illumination of their own experience. Lincoln and Guba (1985) call this construct credibility and use it to establish the "truth value" of a qualitative study. In February 1993, I met with the advisory committee for the last time, discussed with them the findings and showed them how I intended to write them up. The participants clearly recognized the argument as their experience in this process and went on to elaborate how these findings illuminated their experience in many other processes they have been involved in.

In summary, the analysis is based on three kinds of data collected over an ten month period. One, observation of the participatory decision-making and policy process. Two, documentary materials from a variety of sources. Three, interviews with participants in the process about their experience. The analysis was done concurrently with the data collection and in collaboration with the participants. The data informed the analysis and ongoing analysis informed the data collection in a relationship of reflexivity. Taken collectively, the data from the three sources served to locate the participants' experience within the organizational and policy context.

Chapter 4

History And Development Of The Advisory Committee

In this chapter I trace the development of the advisory committee and explore the mandate of my involvement with them. I discovered differences in what was stated in the contract defining the development of a participatory structure and what was actual occurring at the community level.

The local community, defined as a geographic area of approximately 17,000 people and led by a group of approximately 30-40 active participants interested in social planning, had already taken the initiative to develop a committee on mental health services before I became involved with them in April 1992. When I enquired as to why this committee had developed to such a degree, three key points emerged that were agreed upon by everyone.

Firstly, the development of the committee was largely attributed to the director of the local Mental Health Centre, who clearly valued community input and development. He was willing to put a large part of his time into supporting the development of the advisory group, networking with other service providers in the area, and was perceived as being very responsive to the input. People in the community clearly respected him and were confident that he was always acting in response to their feedback. In my conversations with him, he appeared to understand that community members needed certain information to make decisions and was clearly committed to providing the advisory committee with information.

Secondly, the community had a well developed Partnership Group that contributed to the development of the advisory committee. Partnership is a concept in mental health that has gained increased popularity over the past several years and partnership groups are being formed all over the country. Mental health professionals, family members and people with chronic illness come together as equal partners to support one another. In this case the Partnership Group was integral to the involvement of both consumers and family members on the advisory committee.

Thirdly, the local area had a well developed network of local service provision and multi-ministry cooperation. There was a Social Planning Council that had a broader mandate of planning for health and social service resources to all citizens in the area. The advisory committee, specific to mental health concerns was connected to the area's Social Planning Council and members worked on committees of the Social Planning Council.

I noted in my initial contact with the advisory committee that they were confident in their ability to function. This confidence appeared to be based on their experience with the director of the centre and the existing community network. This sense of integration and confidence in being able to take a meaningful role in making decisions in response to the needs of the community was reiterated by the chair:

> Yes, well the advisory committee was formed to look at the needs of the community here, meaning the western group of municipalities, and outside of that and to help with the planning of the mental health services as we see it and hope for in our community. And to lend support to the existing services and people who are giving it. And I think that is what we are doing - we may be looking at other things to do but that is my main focus.
>
> (Fieldnotes, October 15, 1992)

When I asked her about the group's ability to influence decisions she responded:

> Well certainly I think we've spent a lot of time pushing for extra services and trying to get extra staff which the director had already being trying to get but we just added our voice. Our voice was pretty strong. Enough so, I think that they heard and when they were talking about their allotment of staff I like to think we had an influence on that.
>
> ...We wrote letters to the politicians and the Minister in particular with copies to anybody we could think of in the hierarchy of the government services that connected with this. I think that helped.
>
> (Fieldnotes, October 15, 1992)

In short, before my involvement, this committee appeared to be functioning quite well. The committee appeared to have influenced local decision-making, had developed relationships in the community and was anxious to influence decision-making at a regional level. They had developed some lobbying skills and were feeling confident that their "voice" was being heard. They were however only cautiously optimistic regarding their influence beyond the local level to regional decision-making but were determined to "make their voice heard" in the regional arena also.

In January 1992, Mental Health Services of the Provincial Ministry of Health contracted with the agency I worked for to develop " a comprehensive community structure which will advise the ....regional Mental Health Services and other mental health related services, at various administrative levels, on mental health needs and priorities" (contract, December 27, 1991). The mental health advisory committee was to be one piece of the intended comprehensive community structure and my role with them was to facilitate their development and integration into this structure.

It is important to note that the contract was negotiated between the Ministry of Health and the agency I was employed at. The advisory committee did not have any input into the contract nor did they ever see it. When I examined the contract in relation to what was actually happening I discovered disjunctures. The terms of the contract regarding membership of advisory committees were:

> 1. Meaningful "Consumer" involvement will be a priority and will be encouraged through the active solicitation of "survivors of mental illness", family and friends.
>
> 2. Membership in an advisory committee will be obtained through a process open to public input and scrutiny.
>
> 3. Membership will be as broad as possible, ensuring a wide representation from all elements of the local community, including program representation (i.e., child and youth, adult and elderly programs) and could include representatives from:
>   Health practitioners from a broad multidisciplinary base,
>   Health institutions, residential settings,
>   Consumers of services,
>   Community and volunteer agencies,
>   Inter-ministerial groups.
>
> (contract, December 27, 1991)

The membership of the existing advisory committee clearly fulfilled these requirements and it appeared that on membership there was congruency between what was now an "official mandate", sanctioned by the terms of a government contract and what was actually happening.

The terms of reference in the contract regarding function of a "comprehensive community structure" were:

> 1. Each local "Mental Health Advisory Committee" will relate directly and serve as an advisory to a local Mental Health service delivery site and other mental health related services.
>
> 2. The Contractor will develop an organizational structure and process by which local Mental Health Advisory Committees can link with each other on common interests which affect the region as a whole, and through an "umbrella" or "regional" Mental health Advisory, address the Mental Health needs and priorities in the region.
>
> (contract, December 27, 1991)

Before I began to work with the advisory committee, they had formulated their terms of reference. They defined their functions as:

1. to act as advisory to staff at the local Mental Health Centre
2. to advocate for mental health resources for clients of all ages
3. to promote public education and awareness of mental health services and issues

(Terms of Reference, March 1992)

My initial involvement with the advisory committee reinforced that they interpreted their function as influencing and being part of decision-making about all aspects of services, locally and regionally.

I wrote in my fieldnotes after my first encounter with the chair of the committee.

> I attended the opening of the new centre today. The chair of the advisory committee had brought copies of their terms of reference for me to see and also for me to send on their behalf to the chair of the newly forming regional health planning body and the Minister of Health. The committee is very concerned about how connected they will be to these new structures and want to know how the committee will have input into regional decision-making. I am struck by their terms of reference. They are much broader than advisory to the mental health centre. I asked the chair about that and she replied "We see them as all connected and our role of advocacy is very important. And then part of advocating is also raising awareness, so we really do it all."
>
> (Fieldnotes, May 1 1992)

I recognized the dissonance between the function stated in the contract and the function developed by the committee. I noted the apparent continual emphasis on structure in the contract documentation and the emphasis on function in the actual work of the committee. The committee identified advice, advocacy and public education and awareness as their function and were not overly concerned with a structure. On the other hand, the contract clearly identified an organizational structure of local advisory committees in a relationship with local delivery sites and linked to a regional structure but did not clearly identify the function of the committee other than the term "advisory". Detailed explanations regarding the definition of advisory, expectations of committees regarding advice giving or influencing decisions or any expectations regarding managerial or professional practice in response to advice were not delineated in the contract. The contract assumes that involving a broad-based membership in an organizational structure will ensure community-based participation. At the same time, issues were being brought to the committee by mental health management that asked for more than advice. For instance, they were asked to prioritize service needs for the community and were expected to support their decisions with broader community input.

As participating in decision-making was not explicitly stated in the definition of mental health advisory by the Ministry of Health, Mental Health Services, I also began to question the expectations at the regional level and more importantly, my role in facilitating the committee's ability to influence regional decision-making. Not only was I becoming aware of a contradiction between the contract and the committee's expectations, I was also feeling that old sense of discomfort. After all, my mandate was defined by the contract which was to create a structure to advise. How did that fit with an empowering practice? or community control? How could I serve both the needs of the agency I worked for to fulfil the contract and be true to the principles of empowerment by being responsive to the needs and decisions of the advisory committee?

Chapter 5

The Participation Experience: Empowerment Or Compliance?

How committee members experienced participation both individually and collectively is examined in this chapter. Individually, people involved in the participation felt personally better and named this sense of increased self-worth "empowerment", but the actual collective ability of communities to control decision-making (what I'm calling community empowerment) on issues that effect them did not increase. I discovered a huge disjuncture between what people were saying about how they felt personally and whether in fact they had any control as a community over decisions. In addition, I discovered that committee members became more and more accepting of their inability to increase their power and to influence decision-making through this process.

I have separated personal and community or collective empowerment for the purposes of discussion to make visible how the empowerment process works.

Personal Empowerment

Personal empowerment can be defined as attaining control over one's life. I found that consumers, family members, and front line workers involved in the advisory committee gained a sense of personal empowerment in part through providing input into mental health services and being involved in the advisory committee function. This feeling of empowerment is described in many ways in the talk of the participants. Their talk suggests that being listened to, feeling increased control over decisions, having opportunities for building relationships and having access to more information all contribute to their enhanced feelings of usefulness, increased self-esteem and control in their life and their work.

The process of empowerment is best described by one of the members of the advisory group, whom I will call Sue, who is a survivor of chronic mental illness. When I asked her about how and why she became involved in the advisory group, she gave me her story of personal empowerment. What follows is her description of all the things that led her to be able to speak for herself and for other people living with chronic mental illness.

> I'd have to go back on the history of that I guess because it didn't happen all of a sudden. But when I first went to the psychiatric ward, uh I didn't talk a lot. I felt that I was being put on guilt trips. People just didn't understand me at all and I felt that a lot of people there were more detrimental to me so I just stayed away from them (most of the staff). So consequently, I listened a lot and I listened to the consumers - the people, roommates, whatever you want to call us all. And uh found out that I had a pretty good rapport with them and was receiving positives and found that we connected. They were sensitive and if I wanted my space said "fine, see you later" and .... So I thought that was neat and I connected a lot more with the consumers than any staff.
>
> There was the occasional staff person that I could connect with but very few and far between. Um I'm just trying to remember back in those days - I felt very abandoned and I didn't think it was therapeutic ....Anyway, I started working with D. (psychiatric social worker there) and uh I guess in the last 3 years working with her I've made the most progress in my whole life because she allowed me to be. There was no need for defenses. I didn't shut down. I didn't withdraw. It was totally unusual for me and uh what ...without the energy going into defending myself all the time I could progress and work on issues I wanted to change. ...... It was just mind boggling for me. When you think you allow a person to be who they are, what they are and how they are and at their level. She could come down to my level rather than my psychiatrist who says "come and join me". He was up there somewhere. Forget it you know I'm down here. Come down here and help me up - you know. So it was just like I say really impacted my life a lot. So I learned some communication skills, I learned to ask for what I wanted of which I never did before. I learned to be vulnerable because I'd never let anybody know I was hurting and um or that I needed them or that they meant something

to me. I learned to do that because she was non-judgemental and non-critical and uh I guess one of the big things too was the belief in me. She said well I'll always believe in you even though you don't believe in yourself. And she said she would never give up on me. Which through people abandoning me of one sort and another, I mean that was just mind-boggling. I knew that she meant it. So and that's like in the partnership group when we help one another and we're there for one another, its the same thing in the group. We believe in one another. You know, you can get the staff not believing in us but we do. Plus I read a lot. I've read a lot of books .... And being myself now and being more open, I have increased my supportive network with people that I enjoy being around cause I can be myself.

I got more confidence. I learned to speak out because you know if you don't like my opinion - hey, that's fine. You can have yours, I can have mine, they can be different......... And anyway um through this I felt like I had a niche again and through the partnership group and I'm becoming more active and uh I like working one on one with people. I've had excellent feedback from them and uh felt hey this is my niche. Because I never felt I belonged anywhere before. So isn't it really neat to get back in life again. My heart still lies with mental health ...listening to the consumers um I really dislike the injustices toward them from the professionals, from society and .....I guess in a way I want to be an advocate of some sort. .... And I guess with the partnership group I had a ... I learned to speak up by chairing the meetings. Speaking out - I was the spokesperson when they had their meeting of directors and the head nurses from the various areas. And I had to take a tranquillizer on that one. To me it was an important meeting to try and get across that yes we do need a voice and this sort of thing. And uh that partnership was important, staff there were important in the group so I had to settle myself down on that. I had it all written out cause I wasn't confident enough to be able to remember everything and to speak openly, you know in the meeting so..... And then I had copies made to send to everybody cause I figured people only remember 10% of what they've heard anyway. I felt it was important I guess to put that message across.

I hardly ever said a word up until 3 years ago and I'd never speak out in a group until a couple of years ago. ...... it's a gradual process. I had to learn to speak out in the partnership group and I couldn't have done that if I didn't have the confidence of working with D. and getting some social skills. Because to me I was socially really inept. You know there was one time at work at coffee - there were about four of us sitting around and this other person came to join the table and this girl beside me said "Oh, this is B. she just sits there and says nothing and smokes." You know, nobody knew me. And when I went off on disability nobody enquired how I was. I worked there for 20

> years and no one, none of the bosses or nothing enquired. So I suffered a lot...
>
> (Interview notes, October 19, 1992)

In telling her story, she refers to her "partnership group". Four of the people on the advisory group were also members of the local Partnership Group. She describes the purpose and effect of partnership groups in this excerpt:

> And um, this is why I guess I believe so much in the partnership program cause it was an excellent opportunity to - as a teaching and learning medium - for the consumers to learn about what relatives are going through and what problems the staff are having. I think they have a complete switch in roles from telling us what to do and taking control all the time to allowing us to have a voice and a part in it. And vice versa, the professional is listening to the consumer now and relatives are listening to ....we're all listening to each other.
>
> I have a sense of hope ..lets put it that way. Whereas there wasn't that before. In other words, I'd say something and it would go in one ear and out the other and nothing would happen. And they'd say, "oh yes what a good idea". "Oh yes, yes, that's quite valid" - in one ear and out the other ear and nothing was done. I always felt quite hopeless about it and you're batting your head against a brick wall or at the system.
>
> And you know I think with the partnership group the consumers instead of being isolated, one here and one there. .... like we didn't know each other before and uh now when we're coming together, we have a voice which we didn't have before.
>
> Yes and that is very empowering. The supportive network and this is something I really believe in is - with a voice, with the support network of people. Like a couple of relatives who have come to our group have been terrifically supportive. Um, and just that belief in us and encouragement helps empower and you get more self-esteem, more self confidence and rather, you can go out into the world and be part of the world again instead of letting it pass you by and um the whole system before was a maintenance. Nobody got well really, whereas people now can get well. I'm not saying 100% well because people are always going to be sick but they will be one hell of a lot better off and more content.
>
> (Interview notes, October 19, 1992)

It was through the Partnership Group that she learned about the Mental Health Advisory Committee and it was through her increased self confidence that she was able to come and participate at the meetings. She credits the Partnership Group with helping her to be able to speak out at committee meetings and to express herself and credits the opportunity to be involved in the advisory group as another step in the empowerment process. She describes coming to the advisory committee meetings:

> Um, at first I found it very difficult. I guess, the first couple of times to try and jump in. Everybody was kind of monopolizing the meeting. Um, now I guess I'm a little more forceful in getting my word in. Although it is addressed in a way now by N (committee chair).- that on the agenda we will now hear from the Connectors (name of partnership group). So we do have the opportunity without having to have the pressure of trying to jump in on the quote "higher ups". Uh we have our voice.
>
> I was sort of hesitant at first because I don't think they were used to having us there for one thing. Um, when we have spoken up and seem to have valid concerns, wishes and desires and you know like I had mentioned if you want successful programs listen to the consumers..... so and I really believe in that. I think they are starting to listen to us. Before anytime any of us would speak to anybody - professionals, society, anybody - it would go in one ear and out the other. Nobody gave a damn. You know we've been held down for so long and we do really need to have people listen to us now.
>
> (Interview notes, October 19, 1992)

I realized that this person was describing her feelings about herself and her sense of connecting and relationships with other people as vital to and the essence of her personal empowerment process. Her sense of control over her life came through a multiplicity of factors that all interacted with one another. Her individual work with a therapist, how that therapist practices, her experience in the partnership group, her growing ability to broaden her support network, the opportunity to tell her story, understanding her experience as common with others' experience, and the opportunity to practice new skills all tied together to give her the confidence to speak out and participate at the advisory committee. For her and other consumers, involvement in the advisory committee was described as one step in their personal empowerment process.

I noted that nowhere in Sue's story were the outcome of decisions regarding programs or services mentioned as contributing to her feelings. Based on her story and other's experiences it would seem that the outcome of decisions did not emerge as one of the factors that created the environment that people identified as "empowered". At first examination, it appears that there is no direct link between policy and management decisions and feeling empowered. Instead, it appears that personal empowerment is judged by people's responses and a perception of being listened to and valued <u>whether or not</u> decisions or concrete actions being taken in the program and service area reflect the input of consumers and citizens.

This perception was reinforced in an interview I did with a family member (whom I will call Alice), of a person living with chronic mental illness. In this excerpt she is describing a public meeting organized for consumers, community members and providers to participate in prioritizing mental health needs for the 1992-93 budget year. As a long standing member of the group and advocate on behalf of family members she has been involved in several opportunities organized to solicit input and involve family members as partners in decision-making. She is very adamant that she has never felt constrained in any way and has always been impressed by the openness of meetings. The following excerpt from an interview with her identifies her perspective on decision-making in these processes. She is talking about the point at which everyone at the meeting has expressed their opinion on needs and the group is about to embark on a prioritizing exercise.

> A: I felt that it was almost out of my hands at that point. That that (the decision-making) would have to be done by somebody else. I guess perhaps I felt that some of the .. I wouldn't know for sure how to compare our needs with the Alcohol and Drug needs for instance in the community or with the wellness group's needs. I wouldn't know how to priorize that. I'm not sure how much. They probably need a lot and I don't know how much.
>
> I don't think I'm qualified to make those decisions.
>
> BT: So who should make them?
>
> A: Well it could be a consensus of the representatives from all the other groups. ....Um I feel that its not something I can handle. It's over my head and beyond me. I'm quite happy to feed into things but I cannot see myself as going any further than that. I'm not sure who is going to do that.
>
> Cause a lot of it depends .. there's certain politics and there's certain budgets in the Treasury Board area that we don't know about and we never will find out about unless we are there and so we have to sort of gamble and guess and uh say this is what we want - are you listening?
>
> BT: Is there a sense that there is more listening happening?
>
> Yes I have a sense of that but I'm not sure if its because I've been doing more talking to more people and I feel that there has been some progress made in this area, so does that mean they are listening or are they going to do it anyway. Maybe we just got it the way we wanted it because we said you should put a little more money here rather than put it all there or something to that effect. I don't know for sure and I really don't feel I have to dissect that too much.
>
> (Interview Notes, October 15, 1992)

From this example the division between "having a voice" and decision-making is quite clear. Alice felt very comfortable with the process and included, at the same time as she felt unqualified for decision-making and very accepting of a non-role in decision-making. People entering into a collaborative process with policy makers and decision makers are looking for validation of their ideas and in turn validation of their worth to the process. When this validation was forthcoming people felt positive but that feeling did not necessarily translate into the ability or desire to make decisions that affected their lives and might give them more control over their lives. Using the term "empowerment" to describe feeling better or increased self-worth continued to <u>mystify the concept of power and control and facilitated the acceptance of the ruling function of administration and management.</u> The term "empowerment" had very little to do with gaining control or power but the terminology continued to be used and accepted. As I continued to work with this group and encouraged them to become more and more involved in the process of decision-making, this disjuncture between feeling personally empowered through involvement in discussions (i.e. increased sense of self-worth) and acceptance of ruling and therefore absence of involvement in decision-making troubled me. I wrote in my own journal:

> I am really uncomfortable with what happened at the meeting today and I can't quite figure it out. The report on staffing was very interesting and I don't have any difficulty with any of the decisions per se except that they don't reflect much of what we have been talking about at the meetings. Who made the decision about FTE's for what and how many after this huge infusion of new money? More disturbing to me however is not the outcome of the decisions but that they were not even questioned. There seems to be a strong prevailing belief that decision-making belongs with managers. At the same time people are feeling very good about the process. Is it only me that thinks nothing has really changed? Actually something has

> changed - everybody is happy about not being part of decision-making. It seems to me in the past people have complained. Nobody's complaining now. I don't think that is what we are trying to achieve. What am I really doing? What am I facilitating here - increased or decreased potential for community and consumer control and decision-making?
>
> (Fieldnotes, Sept. 2 1992)

Many people called this acceptance of non decision-making co-optation but as time went on and I continued to investigate social relations, I began to see it somewhat differently. Co-optation is defined as the taking over of an independent minority movement or the like through assimilation into an established group or culture. However, if the members of the committee were becoming assimilated into the "management culture" of centralized decision-making, how was this "co-optation" being achieved? This seemed to be the same as my question about "how" power materializes in the experience of participation. I also reflected back on Franklin's (1992) work and her assertion that prescriptive technologies created a culture of compliance and the acceptance as normal and right of external control. I questioned the differences and similarities between compliance and co-optation. What was happening here? I will pick up this line of inquiry later in the chapter after the discussion about community empowerment.

Community Empowerment

As the literature on empowerment indicates, a community can be considered to be empowered when it is self-determining. In my fieldwork, I found many instances in which the collective community I was working with was not self-determining.

One instance of the community feeling alienated from decision-making processes occurred when our advisory committee developed a process to ensure that funding being requested by service providers was in fact an identified need in the community. One of the service providers from the area brought a concern to the advisory committee and wanted help in advocating for increased service. Both the committee and the director of the centre (who had the responsibility of negotiating with the agency regarding the funding request, although as it turned out had no authority in the decision-making) wanted to make sure a broader representation was consulted before supporting the new service. The advisory committee worked with the service provider and the director to bring together people who live and work in the immediate area that the funding was being requested for, to discuss the need. The committee was very committed to a proper process before funds were allocated and were working hard at being responsible and fair. The following from a subsequent advisory committee meeting is indicative of the frustration associated with this process.

> Director: We had the meeting with the people in S. and it was a very good meeting. Unfortunately, the process got short circuited somewhat because before the meeting I got instructions from headquarters to fund the service for $20,000. So instead of it being a participatory consultation meeting and decision-making, it was a meeting to validate a decision that had already been made.
>
> Committee Member: Yes, it was really quite annoying. Quite frankly, the political process, because an elected official was putting pressure on the Ministry, pre-empted our community consultation process. It seems a waste of time to put all of that effort in and then to be totally ignored. I don't think what we were doing even entered into their decision-making process. I guess we need to accept this somewhat because the Ministries are in transition and they are not used to dealing with communities that are organized. But it feels like going into negotiations without any power. We have always been passive recipients of whatever is given to us and I think we want to change that but the message doesn't seem to be going anywhere. Sometimes I feel like we are more ready to implement

> changes and a new way of doing things that the bureaucrats are to respond to us. I feel like we are being asked more and it appears that we are being listened to but then something like this happens and I think nothing has changed.
>
> (Fieldnotes, Mental Health Advisory Meeting, Aug. 12, 1992)

In this case, political pressure from an elected representative appeared to influence the decision-making and ultimately the ability of the committee to decide on services responsive to community needs. In addition, it made a mockery of the participatory process the community was committed to. Disturbing to me, however, was the acceptance of being "in transition" and the acceptance of being "passive recipients" in the process.

The communities' quest for counselling services responsive to their needs was another instance where they were unable to influence the decision-making process enough to be considered self-determining. Many opportunities to consult arose from government initiatives and were evidence of the participatory ideology permeating human services during the time I worked with the advisory committee. For several years before this barrage of consultation opportunities, affordable, accessible generic counselling had been repeatedly and consistently identified as a community need by members of the community I was working in and by service providers. The committee reiterated this need at every one of the various consultations.

There are several counselling programs in the community but they are all tied to specific criteria that are almost exclusively defined by the funding source, not necessarily by the need identified in the community. For instance, there is free counselling available if a member of the community is identified as suicidal (funded by MOH, Mental Health Services), or if a community member has an established drug or alcohol addiction (funded by MOH, Alcohol and Drug Programs) or if a woman in the community has come forward as a victim of violence (funded by Ministry of Women's Equality). However, if someone in the community, doesn't fit one of these pre-determined categories, it is very difficult if not impossible to access a counselling service. Even if a person does "fit" the criteria finding the match between the person's needs and the appropriate program is often a long and arduous task. This process leaves people feeling frustrated and angry and often results in them giving up before they get help. If they did find a "fit", most counselling services in the area have very long waiting lists. In addition, the advisory group recognized that in many cases, the "help" offered by these various programs is very similar and the categorization had the potential to lead to duplication of programs and services.

Also people trying to access assistance don't identify themselves as "an addiction problem" or a " victim of violence" problem. As one member of the advisory committee said in one of our meetings:

> My life just doesn't fit into a category and somehow it seems nuts that I have to figure out and label my reason for asking for help in terms that fit the help. I don't need a label, I just need someone to listen and offer support. Then maybe I'll figure it out and be able to help myself.
>
> (Fieldnotes, Sept. 2, 1992)

Therefore, the need identified was for not only increased counselling services but also for a generic service, not tied to specific "target populations", "diagnosis" or "funding sources".

Repeatedly, the plea was made that these categories were a barrier to accessing needed resources.

In an attempt to be proactive, one of the members of our advisory group was working with a sub-committee of the local social planning council to develop a proposal for counselling services responsive to the community needs. The proposal developed was clearly for a generic service, not tied to any specific "diagnosis" or "target" population, in response to the community feedback. In other words, under the terms of the proposal, people would not have to identify a specific problem in order to access counselling and there would not be any restrictions as to gender or age etc. As specific issues emerged in the counselling, they could be referred to more issue-specific counselling if that was appropriate. The intent was to make it as simple as possible for people to access assistance when they needed it.

The proposal was developed and distributed to several government ministries and in fact suggested to the ministries that they cooperate together from their "specific categories" and work out a way to fund a joint program. The following is an excerpt from a meeting when the member was reporting on the outcomes of the proposal distribution.

> We finished the proposal and sent them to various places to see if we got any bites for funding. Well, we got a bite but I think we were looking for a salmon and we got a dogfish! Mental health services has agreed to fund counselling services in our area but it will not be for generic services. Because the funding is from Mental Health Services and money in the Ministry of Health has been transferred from institutions to community, this money has to have an impact on the admissions to psychiatric facilities. We are still negotiating it but it will be for people who without it have a high potential for admission to hospital. This means that there is still a huge gap in generic counselling services that we still need to work on.
> (Social Planning Council Meeting, October 22, 1992)

In order to meet the administrative difficulties encountered by the institutional sector, whose funding was being decreased in order to support the evolutionary change process in health, increased funding for community programs such as this counselling service had specific criteria attached to it. In the words of a Mental Health Services administrator and negotiator of the contract:

> The bad news is that there are very definite strings attached to the money. The money is for, I guess you would say urgent type cases - again its not broad-based funding for general adult counselling. It's got to be applied to the kind of person that if they didn't get immediate short term stabilization or crisis intervention brief therapy that they would probably end up being hospitalized. The only money that is available is to try and help people stay out of hospital because the hospital funding is being held to no increase.
> (Fieldnotes, October 14, 1992)

Services are not funded just because there is an identified need but are the result of making rational decisions based on objective data and other influencing factors. At the same time as it was being recognized that community members were in a position to know what is needed and were being encouraged to participate in <u>needs identification</u>, the institutional sector was being expected to manage with less. The administration was in the position of having to <u>rationalize</u> changes in the hospital and therefore had to <u>organize</u> the community services in such a way as to show the logic of reduced allocation to institutions. Through this set of relations and process of rationalization and logic, the need for affordable, accessible, general counselling became a short term stabilization and crisis intervention service to keep people out of hospital. Therefore, the needs of the community and the ability of the community members to impact decisions are severely limited and as a result, the 'enhanced services" often became diluted or changed to programs which are delivered in ways other than those originally envisioned. As one member of the advisory committee aptly put it:

> "We put a circle into the tube and it came out a square."
> (Fieldnotes, October 14 1992)

Another instance occurred when the committee worked in conjunction with the Social Planning Council to develop a proposal for a Neighbourhood House or Family Place run by community members and responsive to community members and needs. Support for families through providing a gathering place and opportunities for sharing experiences and education was considered to be one way of promoting mental health in the community. The process to develop the proposal had included the development of a community/family advisory group and they were highly involved in decisions affecting the proposed Neighbourhood House. In much the same way as the need for counselling services, the need for a Neighbourhood House was confirmed in the community consultations undertaken in the time I was involved with the group. The government was responsive to the needs identified in the consultations and decided to provide some funding for the establishment of a Neighbourhood House in the area. However, as soon as the group became aware of the contracting process, they recognized a flaw. There was a long discussion of this at one of the meetings.

> The "Schedule A" is being written by the Ministry. If it defines the service where is the community in the process? When is the community going to get to write the "Schedule A"? Isn't that why we included community members and families in the planning?
> (Fieldnotes, October 23, 1992)

"Schedule A" is the part of the funding contract that defines the service or product being bought by the contractor. It is negotiated between the government body funding the service and the agency or community group providing the service. In this case, it was with a local agency which was part of the community/advisory planning group for the Neighbourhood House. The government ministry representative wrote the parameters of what was being bought and went to the local agency to have it confirmed and signed. The "Schedule A" was the determining factor in decision-making for what was provided to the community through a Neighbourhood House, how it was run and who was responsible. The control of the community planning group was effectively removed and was gathered back to the government administration level even though the ideology of community participation was being espoused. Given the community's commitment to participatory management of the Neighbourhood House, the group was very upset at the government process used to complete the funding arrangements.

What followed the expression of frustration about the lack of involvement of the community in the contracting process was very interesting. Committee members wanted to suppress expressions of impatience and anger. Some examples of comments that accompanied frustrations about both the counselling service and the Neighbourhood House were:

> We don't want to make too many challenges about this. I think we have an opportunity here to make this fit in the community. We can take this and mold it till it meets our need. (service provider)

> I understand how frustrating it is because the powers that be don't seem to understand the process we are in but I think we have to be patient. After all, it is better than

> it has been for a long time. (service agency representative)
>
> Well we have to realize that we are in transition and we are being listened to - after all we are getting some funding to support the neighbourhood house idea. (user of services)
>
> (Fieldnotes, October 23, 1992)

I left this meeting feeling very uncomfortable. We had influenced decision-making because funding was allocated to community identified needs but beyond that we could not shape the resource to meet the need. That decision-making power remained with government administrators. Most disturbing was that people were unhappy with what was happening but very willing to accept it. I wrote in my journal following that meeting:

> It seemed over and over again at the meeting yesterday that what was emerging was not what we are asking for. Is this really community empowerment or is it something else? I can't help but think that something else is going on here. The other amazing thing to me is that everyone is being so accepting of it. What are we hiding by doing that? What has made us so compliant?
>
> (Fieldnotes, October 23, 1992)

I want to pick up the discussion about co-optation here. More and more I was seeing compliance and the willingness of committee members to accept centralized decision-making even though they clearly knew it was not what they wanted. Here is where I see a difference between compliance and co-optation. Co-optation involves assimilation where people gradually take on the characteristics of another culture and accept it as their own. The members of the committee were not assimilated into the "management culture" because they <u>recognized power and control in decision-making was centralized but they became less and less willing to challenge it.</u> Compliance and acceptance of decisions that weren't congruent with the community wishes was being created because of a perception that "we are being listened to" and that government administration was in transition and trying. There also seemed to be a belief that if the committee worked hard enough to make it fit the necessary changes would be realized. I had to ask myself how my facilitation and participation in this process contributed to the perception that bureaucratic practice was changing and in transition. "Who" was listening and why did the community members think it was their responsibility to make less than adequate administrative practices fit the community? Was it I who was listening, and as the "facilitative tool" of the ministry, giving the message that things were changing that really weren't? Was it I who was giving them the message that their role was to "make it fit" and was I contributing to their ability to do that? If so, what did that accomplish for the ministry?

These experiences led me to conclude that this process is not accomplishing what it set out to do. In regard to mental health planning, the community is not self-determining and therefore cannot be considered to be empowered. Individually, people involved in participation processes were feeling personally more involved and valued but the actual ability of communities to control decision-making on issues that effect them was not increasing. There seemed to be a huge disjuncture between what people were saying about how they felt personally and whether in fact they had any control as a community over decisions. I began to look for what it was that created this disjuncture.

I continued to be troubled by people's apparent acceptance of not being able to participate meaningfully in decision-making.

Initially this committee had been very concerned about their ability to influence regional decision-making and were very confident in their ability to do so. Now they appeared to be collectively accepting of the fact that decisions were being made that appeared to negate their input. Again, there was an apparent acceptance of the ruling function even though they said they wanted more control. Committee members appeared to not only accept non-involvement in decision-making but were also, by "making things fit", beginning to act in a way that further ensured they not be involved in decision-making.

At this time I began to ask myself how interactions and events outside the group's personal experience (social relations) contributed to them acting in a way that resulted in not being involved in decision-making. I wondered at my contribution to this as facilitator of the process. In order to try to explicate what stands behind the disjuncture between their expressed desire for control in decision-making and what they are apparently willing to settle for, I looked at my practices or activities and practices or actions outside the experience of the group in the policy and organizational context that supported or provided barriers to members' involvement in decision-making.

Chapter 6

The Practice Connections: Threads That Bind

Drawing from my conceptual framework, I knew I needed to examine the activities of people in this process in order to uncover how they are knitted together to organize my experience and the experience of the advisory committee. I had discovered the actions of the committee and I proceeded to examine the practices of facilitation and the practices of decision-making. This chapter uncovers the activities related to each and shows how they work or "knit" together.

Practices Of Facilitation

As the facilitator of this process I saw my role as gathering information, sharing information, listening to people talk about receiving service, providing care and managing services to help them link the ideas together. I worked to help people put their views across in a way that could be heard by people who might have a different perspective. I also saw a role for modeling inclusive behaviour. To this end, I became involved with many different groups who had an interest or experience in the mental health system and I listened. This included people working within the Ministry of Health system and hospitals as well as people working and living in communities. I approached my work with all these groups from an empowerment framework. That meant that I did not consider myself an expert about their experiences and environments and I tried to build on existing strengths within communities and service delivery systems. I found the environment at the advisory committee meetings to be generally very respectful and inclusive of everyone.

For example:

> The meetings are chaired by a family member. Staff at the centre and even the director are there as participants but do not dominate the meeting. The director reported on the new positions hired with the new budget money. There was a very interactive discussion with everyone participating. The director is very respectful of everyone, interacts well and appears very aware of involving the consumer group.
> (Fieldnotes, Advisory Committee Meeting, May 13, 1992)

There was a definite sense that consumers, family members and citizens had a very valuable role to play and this was verbally and non-verbally reinforced. Professionals listened attentively, interacted and respected the right of consumers not to contribute if they didn't choose to.

> A very interesting dynamic happened at the meeting today. B. came to the meeting but was not looking well and was withdrawn and sitting in the corner at the beginning of the meeting. The chair asked her if she wanted to report on the consumer group and she gave a very terse "I don't feel like it today." Everyone respected that and one of the other consumers said "okay" and began to talk about what the consumer group was doing. No one asked questions or tried to draw B. out - just let her participate in any way she could on that day. At the same time they didn't ignore her, either. People made eye contact and referred to comments she had made at earlier meetings etc. and generally accepted where she was today. As the meeting progressed, she became more and more involved until by the end of the meeting, she was fully contributing to the discussion. She left the meeting looking very different than when she came into the meeting. It was quite amazing and really difficult to pinpoint what it was that made the difference for her.
> (Fieldnotes, Advisory Committee meeting, October 14, 1992)

As identified by Sue's story of personal empowerment, communication and facilitation skills and practices, such as active listening, openness, acceptance and respect helped create the environment for this person to come to the meeting and be left alone.

Over time I realized that those skills or practices were present in the group collectively.

I began to look at what it was in the planning and agenda setting that helped to develop supportive environments for people to feel that they had some control over their experience in the group. After one of our earlier meetings, I wrote in my fieldnotes.

> This meeting was controlled by two members (local doctor and community member) who dominated the conversation. They were very concerned that the committee "do something". There was such a lengthy discussion (between the two of them) about statistics and evaluation of the programs that we never got to the rest of the agenda. The people from the consumer group said nothing the whole meeting. The chair talked to me after the meeting and she was upset with the way it had gone. She expressed frustration because she has seen this happen at previous meetings and is worried that the consumer interest and involvement (and for that matter, her own because she is a family member and wants to be heard also), will drop off if this continues. On the other hand, she is worried that some of the professionals will drop off if this committee doesn't produce something tangible. We decided together to try and structure the agenda so that the report from the consumer group is always first, to see if it would break down the dominance somewhat and would ensure the consumer group got heard.
> (Fieldnotes, Advisory Committee Meeting, June 10, 1992)

This change in structure proved to be successful. It was mentioned by Sue in my interview with her when we were discussing how free she felt to speak at our meetings. She said:

> Um, at first I found it very difficult, I guess, the first couple of times to try and jump in. Everybody was kind of monopolizing the meeting. Um, now I guess I'm a little more forceful in getting my word in. Although it is addressed in a way now by N (committee chair).- that on the agenda we will now hear from the Connectors (name of partnership group). So we do have the opportunity without having to have the pressure of trying to jump in on the quote "higher ups". Uh we have our voice.
> (Interview Notes, October 19, 1992)

However, success is relative because the fear of the chair regarding the participation of the professionals was well founded. By changing the agenda and contributing to equalizing the power between those who traditionally dominate and those who are disempowered, the group lost the regular attendance of the two people who had traditionally dominated. They continue to be involved and interested but stopped attending meetings regularly. When asked about why he had stopped attending, one of the members replied:

> All we seem to do is talk and I want to get things done. People don't seem to be very interested in getting that survey out or collecting the statistics we need and I'm really busy. I'm still interested and I want to see better resources to meet the needs of people with mental illness but I would like to see them address the problems at the hospital or get some beds out our way and that isn't happening very fast.
>
> (Fieldnotes, September 12, 1993)

What happened here seems to be an example of how fundamental differences materialize in the everyday world. The consumer, family members and citizens were predominantly interested in a process that allowed them to be valued. They wanted to be heard, to share information and to work towards actions that were relevant to their lives and health. The busy professional, trained to produce a plan of action and fix a problem perceives the relationship building, valuing and ultimately the actions to include all people as laudable but secondary to the "real work" of needs assessment, prioritizing, evaluation and statistical analysis that has to be done and is traditionally valued. These fundamental differences remained invisible in the talk of planning and goal setting and were never labelled as fundamental differences in power. No discussion of how shifting the focus of meetings would shift the distribution of power ever occurred. The people who remained actively involved were those who saw the reason for the committee's existence as including everyone and they saw the benefits in participation not statistics. Those who valued evaluation plans and collection of statistics became less involved as their dominance of the group lessened. The contradiction between the fundamental differences in what or whose knowledge is valued and how those beliefs were played out in practice remained undiscussed and invisible.

Sharing information was a vital activity to facilitating the inclusion of all people. The personal conveying of information was very important to people. The following excerpt from an interview with Alice after a public meeting to discuss regional mental health priorities exemplifies this feeling.

> I like to hear what you tell us when you come in person to tell us about this and where its going or a similar statement in writing if you're not there ....Paper just doesn't help me at all. I often get a lot of paper - a lot of people go to a lot of meetings and give a lot of paper and I just can't handle all that. I do as little of that as I can.
>
> ....If that group is going to do nothing but produce paper I think that's unfortunate and they know that already probably - that's nothing new. But if they can come to our meetings, whethtr its next month or whatever and tell us about something that is progressing, that's great, because people want to know that! I want to know that.
>
> (Interview Notes, October 15, 1992)

As part of my role to link people together I was always bringing information about what was happening beyond the local community and making the linkages for people. The Director of the centre brought information to the group about what was happening within the Ministry of Health and his centre. Over and over again, we were told how valuable this was and how nice it was to be informed.

We were also told in no uncertain terms that producing mounds of paper to distribute information was not useful. My notes of an early experience I had with the director and the committee indicate this.

> The director and I met last week to try and respond to some of the concerns raised by some people at the meeting last month re the collection of statistics. There are reams and reams of statistics that the Ministry keeps. We looked at them and tried to find a fairly simple way to organize them that might be useful to the committee and to attach to any documentation they might do. We decided on giving them some of the data and suggesting a sub-committee of the group work with me to pull them together. We talked a lot about it and decided it wasn't very empowering for us to take it out of their hands and do it all for them. We went to the meeting today and showed them what we had done and asked if they wanted to form a committee to work with me. It fell on totally deaf ears! Obviously producing statistical documentation is not a priority with the group. The director has a problem because the politicians want statistics from him but the committee sure isn't interested. The director and I just looked at each other - we certainly got a clear message about the interest in producing documentation. The committee did ask me to go through past minutes and pull out all of the community needs that have been mentioned in the last 18 months so that they have in one place a list of needs that they can refer to and perhaps priorize. I was also told to make it no longer than one page - I could, however double -side it!
> (Fieldnotes, August 12, 1992)

I began to see that we (myself and the Director) were key to people on the committee feeling in control of their experience at the meetings and empowered to speak out about community needs. We did this through our personal relationships with members of the committee and by being responsive to them. They did have a sense of control over how they conducted themselves and in our responses to them, we did respect their decisions. Part of the information we shared helped committee members understand the system and prepare for interactions on a regional level. For instance, because both of us were on the planning committees for public meetings, we knew what would be expected of participants and almost coached them to be comfortable in participating. I went through the minutes and identified needs and the committee went through a prioritizing exercise and made a list of priorities for our area. This list was then photocopied and representatives went to the large meeting with copies of priorities and prepared to speak to them. The chair speaks to me about her feeling of being prepared for this meeting in our interview:

> Well, thanks to you. You offered to do a little bit of research and got back to where we started and found out what we were doing and listed some of the things. We priorized them and then from there we just made a list - brief as I could because I know people don't read a lot and uh prepared it with your help. Thank you very much. I took them to the meeting and that was a very good idea because I for one do not always have information stored to present quickly. I found it very helpful to have something written down. Plus uh we were probably the only ones that had it and uh felt I felt that we were quite efficient. And I think that it was quite well received . There were several people that looked at it. That's my guess anyway.
> (Fieldnotes, October 15, 1992)

I began to see how facilitative practices or activities have a contradictory or double effect. Facilitative practices included modelling inclusive behaviour, information sharing, linking groups together, active listening and respect. From the above example, it might be concluded that my work in this regard contributed to the group working together and members of the group feeling valued and active contributors in the process. In other words, I contributed to the group feeling empowered and competent at local policy-making. However, knowing that the committee's ability to influence decision-making regionally was not increasing, I also came to see this as a very limited sense of empowerment.

Furthermore, I realized that my skills and knowledge helped them look and feel very competent at regional meetings and in the eyes of administrators. We were "acting" in a way that was approved of and fitted with the Ministry of Health expectations. Group members, particularly non-professionals (family members and users of services) were attending meetings with administrators and distributing prioritized lists of needs, speaking up and presenting effective reports. This, of course, confirmed to administration that this group had achieved meaningful consumer participation. Because the committee and by extension the community "looked good" in the eyes of administration, we were "successful" at getting funding allocated to the area. For instance, the reason our community was allocated funds for counselling was articulated by an administrator:

> The area that didn't get any of this funding was P. and they were quite upset about this and rightly so. I was a big part of making that decision and I'm standing by it because they haven't got a mental health advisory committee or a social planning council in that area that has come up with a community consensus on what the needs are and what agencies could provide the services so they just aren't organized or ready yet and I have really tight time lines. This community is organized and has done the work so the allocation came here.
>
> (Advisory Meeting, Oct. 14 1992)

As we discovered in the previous chapter, this allocation of funding became transformed into something the committee was not asking for but because money was being allocated to them they felt "listened to". I came to see that the reason we were being listened to wasn't entirely because of a commitment to the value of community participation but because, partly through my actions (facilitative practices), we were organizing ourselves into an acceptable mold. The allocation of funds became the reinforcer that, along with my activities that contributed to making members of the group feel valued, organized the acceptance of non-effectiveness in decision-making beyond their experience at the local level. Over time, their initial demand to influence regional decision-making lessened even though they had less and less influence in that area. Reflecting back on Smith's work, I saw this transformation or ordering of both my actions and the actions of the committee members as the result of social relations. The act of facilitating the development of this group and their participation did not begin and end with the committee but was part of a set of social relations which had to do with the way in which the state attempted to regulate and rationalize the distribution of public money. I came to see my facilitation as a ruling practice and part of what Smith would call the ruling relations. "Empowerment" and "ruling" are, of course, contradictory both theoretically and ideologically but in fact were not in my practice experience. My "empowering practice" had become a new management technology within the policy framework of participation.

Practices Of Decision-Making

> The whole issue of generic counselling was a big topic for discussion today and still doesn't seem to be meeting the community's needs. It's like the whole thing has taken on a life of its own. However, the committee was asked for input on the new space requirements at the Mental Health Centre and how to utilize it in the best interests of the community. I think it is likely all of our suggestions will be implemented and the centre will truly be community space. It seems to me that it is only on funding issues that we get ignored. I wonder how that happens?
> (Personal Journal, Nov. 2 1993)

The examples of the community not having control over decision-making are all related to determination of funding for community identified needs. In order to examine the practices that contribute to these decisions, an understanding of the organizational context and funding and budgeting process is vital.

Mental Health Services is one division within the provincial Ministry of Health. The division is divided into regions throughout the province and districts throughout the regions. Each region has a Regional Director, who is responsible to the Director of Regional Operations in the Ministry of Health, Mental Health Services Division. Within districts there are specific service delivery sites known as Mental Health Centres.

There are three Mental Health Centres within the district that is the focus of my study. The term region is confusing because it is used interchangeably to describe the larger region that the Regional Director has responsibility for and the district that is the focus of my study. The term "area" is used to describe the local geographic catchment area of each centre.

The Mental Health Advisory Committee that I worked with relates directly to one of the centres. Within each centre there are three program areas:

- Adult Community Support (ACS) which encompass all support programs to people with chronic mental illness,
- Adult Short Term Assessment and Treatment (ASTAT) which encompasses personal, family or situational crisis and
- Children and Youth (C&Y), which provide services to children and youth 0-18.

Each service centre provides these programs to their respective geographic catchment area and has a Director, three Coordinator positions (one for each program area) and line staff to deliver the services.

In addition there are several regionally (district) developed programs:

- Emergency Mental Health Team that provides emergency service regionally,
- Intensive Community Support Team that provides intensive support to 40 people with chronic and serious mental illness,
- Residential and Rehabilitation Programs, which provide housing and support to 175 people with chronic mental illness living in group homes and
- Elderly Outreach Services, which provide psychogeriatric outreach services to elderly in their own homes and in care facilities.

The regional (district) programs each have a Coordinator and are responsible to one of the centre Directors. The Directors are responsible to the Regional Director, who has responsibility for the larger region. Historically, this hierarchy has created difficulties in coordinating services across the geographic area (district) encompassed by all three centres.

In an effort to enhance the coordination, the three local Mental Health Centre Directors adopted a matrix model of management. The three directors have been utilized as "regional (district) program managers", so all the ACS programs are the responsibility of one director, ASTAT the responsibility of another and C&Y another. Similarly the regional programs have been delegated as the responsibility of certain directors regardless of their location. The local directors have maintained nominal clinical directorship of their local area centre and the responsibility for community development in their respective geographic area.

While this matrix model has brought an important unity to the program areas regionally (district), it has not been without its detractions. The actual operation and management of local service centres, including staff support and much of the handling of contracted services has been delegated to the Coordinator positions. Many perceive this to have appreciatively reduced the amount of time Coordinators can spend on clinical activities, thus increasing the workload of subordinates. There is considerable unhappiness with this management structure among line staff in the system. Some comments I heard were:

- management needs to be more connected to service delivery and clients
- we need more communication; more honest communication
- more consultation with staff prior to decisions being made
- need to reduce the layers of management
- directors need to be at their respective centres to support staff and to provide leadership
- coordinators are too involved in administration at the expense of clinical

(fieldnotes, Sept/Oct. 1992)

Because this system is seen as largely failing to keep local directors in touch with their local catchment area it is currently being questioned as appropriate for current health policy directions. Some are suggesting that local coordination, management of integrated health services and community development be considered first priority in order to provide the environment for the public to participate in health decision-making.

Within this complex, hierarchical structure, a process for budgeting exists. Planning for the next fiscal year's budget begins in the June of the previous year. For example, planning for the 1993/94 mental health budget began in June 1992. During June, July and August of that year, government managers prepare estimates to maintain the current level of services. These preliminary estimates include:

- outstanding expenses (bills or contracts with known costs higher than the current year),
- estimates, based on last year's expenses, of what it will cost to continue to operate programs and services, including expected wage increases for the next year (includes allowances for wages and non-wage inflation, changes in use of services and population).

Beyond estimating the funds required to maintain services, government managers from each program prepare issue papers. These documents outline programs, expansion of services, special projects or new initiatives for which new and increased funding is being requested from government.

During the fall, budgets from all programs of the Ministry of Health are finalized, based on direction from the Deputy Minister and Minister of Health, and Treasury Board. From November to February, the ministry's budget is consolidated and processed through the Ministry of Finance.

All ministry budgets are collected into a single document called the estimates, which is tabled in the Legislature in March. There, MLAs review and debate the estimates, eventually voting on appropriation of money for each ministry. This budget process is competitive both between and within ministries. The prioritizing of needs that we saw was so valued by administration when done at the community level makes sense within this context. Priorities and the defense of them is vital to the argument each ministry or division within a ministry must make in their budget request. Given the current "policy of participation", an argument that includes concrete evidence of "meaningful consumer participation" and community consensus is very convincing.

Once approved in the Legislature, Ministry of Health, Mental Health Services is informed of its budget and begins the process of contract renewal and development of any new initiatives.

In the district where I was working, budget management responsibility was at the director level for both the local centres and the regional (district) programs they are responsible for but budget authority rests with the Regional Director and Regional office. The Regional Director is responsible for the regional budget but all contracts must be processed up through the system to the Executive Director of Mental Health Services to be signed off. This process takes approximately 3 months and is delayed by approximately 3 weeks every time a contract is sent back for clarification. However, each Director is responsible for negotiating contracts in his/her regional (district) program area. In some cases contract negotiation is delegated to the coordinator positions. Therefore Directors and Coordinators are in the position of negotiating contracts and budgets that they don't have final decision-making authority over. That authority is centralized although it is done in consultation with Directors. The combination of the matrix model and centralized budget management has led to a situation where in many cases the local service delivery agencies are negotiating contracts with a Director who is unfamiliar with the local area and issues (because he/she is the Director in another geographic catchment area) and then the final authority and decision-making rests with another body equally unfamiliar with local issues. The complexity and distance embedded in this system reinforces the need for "accurate, objective" information and knowledge. The people involved in making decisions have no experiential or subjective knowledge to rely on. All of their rationale and arguments require and utilize objectified knowledge that I came to understand is produced through a complex system of documentation and is organized through this complex organizational and reporting structure. This objective information has become synonymous with good and trustworthy information and it is taken for granted by ministry officials that complex statistical information and documentation systems are the only means of producing reliable information. This was very evident at one of the advisory committee meetings when there was a long discussion about the need for the Partnership Group to develop a survey. The group had identified a need and was in the process of planning an activity drop-in centre for people with chronic mental illness. Ministry officials were suggesting that a survey of the area would assist the group to see "just how many people would be interested in an activity centre" (Fieldnotes, Advisory Meeting, Sept. 2, 1992). The group reported at the meeting that they were in the process of developing a survey and were going to circulate it to the local Doctor's offices and community agencies. The Partnership Group saw this as an opportunity to inform more people about their group and include new members but never questioned the need for an activity centre. Ministry officials saw a survey as a means to provide reliable information about the need for a centre.

Another instance where the value of objectified information was clear was in a discussion about how the advisory committee would document and evaluate the outcomes of increased funding for mental health services. After a long involved discussion about how the group might collect statistics and document and measure outcomes, one of the "consumers" on the committee said, "Why don't you just ask us? We can tell you if things are better in our life and if we get more support or whatever." The response she got from service providers was " I know you can tell us but they want real information that we can document." (Fieldnotes, Advisory committee Meeting, June 10, 1992).

As we see here, this objective knowledge (statistics collected in a "scientific", "reliable" way) stands at odds with the subjective knowledge (experience) from the community. But, as I discovered, the subjective knowledge that arises from experience was never seen as a substitute for objective knowledge. Rather, this knowledge is "used" by bureaucrats in a different way but one which continues to value objective information over the community's subjective knowledge. The community's knowledge is recognized as real and factual but is somehow suspect because it may be unique or perceived as not reliable.

The separation of experience from the creation of knowledge that is valued is evident throughout the whole budget process where the real experiences of people get separated and distanced through a variety of practices or what Franklin (1992) calls prescriptive technologies. For example, the development of issue papers is integral to the allocation of funding in the new fiscal year.

> In developing the mental health issue papers, mental health services will refer to the five-year strategic plan for B.C. and will "touch base" with the local and provincial advisory groups for advice about service development priorities for the next one to five years.
> This strategy is the result of community groups, consumers, caregivers and governments coming together to discuss how mental health services for children, youth, adults and the elderly can be improved. Each year, between 1992 and 1997, new money will be requested to meet the strategic planning goals.
>
> (Information to participants,
> Mental Health Budget Planning Meeting,
> September 22, 1993)

As we see here, the issue papers are developed by managers by referring to the five year strategic plan. Through this process the very real issues of the community get transformed into an objective document called a strategic plan that is then used to develop the basis for further funding. In this way the budgeting process and practices become totally separated from the reality of the lives of both the people the system serves and the people who work in it. This practice or prescriptive technology used for decision-making on budgets eliminates the potential for communities to be self-determining. When attempts are made to include communities in the process, the efforts appear to fail because the process has taken on a life of its own that is separate and distinct from their experience. It is very difficult to bring the meaning of that experience back into the objective practices.

At the time I was working with this group, there was an attempt to bring community members into the budgeting process through a large public budgeting workshop designed to identify needs and prioritize them for input into the process. This meeting was held in September after the preliminary estimates were done and presumably after the issue papers had been developed, although that was not stated explicitly. The need to categorize and prioritize in order to make decisions became problematic and frustrating for people at the meeting. Community members expressed frustration at "having to categorize everything." Categorization came up repeatedly as an issue when the group was trying to prioritize. Of course, the need for categorization is the direct outcome of prescriptive technology or breaking the work into clearly identifiable sections. This technology then orders the work so that community members are in the position of categorizing and prioritizing groupings that do not fit their experience. In order to fit into ministry-prescribed categories, community members felt they, too, must fragment issues. At the meeting community members from all geographic areas and representing many different populations identified a group of four priorities but vociferously resisted ranking them in any order.

> There were approximately 150 people at this meeting representing a very diverse group of issues and people. Given that, it was amazing that they came up with very consistent information. While I was preparing the report, it was very easy to identify the four main priority areas. What was also very interesting was the absolute resistance on the part of the group to say any 1 of the 4 areas was more important than another. One fellow in my group became very angry and very articulately expressed his frustration at being put in the position of what he called " making us fight with each other" He went on to say - "You are asking us to compare apples and oranges. Why do we always have to pick one top area. Can't we try to find more creative solutions and support all of these areas. I'd like to try that. They are all related."
>
> (Fieldnotes, September 28, 1992)

The practice of prioritizing is in place in order to decide who is most worthy of service and assists bureaucrats to make their decisions and discriminate among competing needs and groups. This is part of the social relations that organize community participation. This practice leads to polarization of groups and pits groups against each other rather than promoting cooperative partnerships which is the fundamental premise of community involvement. What the people at the meeting were objecting to was the competitiveness embedded in the budgeting process between and within ministries being pushed downward into the community action and relations. This was felt as a huge contradiction. At the same time as my actions were promoting "cooperation and good feelings", another set of activities was "making us fight with one another". In addition, because the standard decision-making processes of ministries are hierarchical, there is a commitment to the authority on prioritizing being at the top of the hierarchy which prevents the community from being self-determining.

In order to assist with the practice of prioritizing, pre-determined labels such as "high risk, "low risk" and "target populations" are put in place to screen communities who qualify for service according to pre-determined criteria. As previously noted this practice of categorization has been identified as a barrier to community involvement and community decision-making. By removing the person and creating labels that must be talked about and understood differently than talking to each other about themselves, their families and friends and/or people known personally as clients, mental health is objectified. It becomes the proper domain of "authorities" or "professionals" and outside the sphere where community members feel competent (unless, of course, they have access to a government funded facilitator (me) who assists them to feel competent and begin to organize themselves to objectify the experiences of the people they live and work with).

I have discovered that decision-making practices in the budget process and organizational context are prescriptive technologies that include documentary practices that separate subjective experience from the process through documentation, categorization, priority setting and complex arrangements of reporting relationships and hierarchies. For instance as noted in Chapter 5, a "target group" of people who require crisis intervention to keep them out of hospital is constructed in order to decide what service to provide and who is eligible for service. This categorization leads to the creation of a "priority" because crisis cannot be ignored and reduction of hospital usage is a policy. Now the experience of people who come for counselling assistance and what they know about themselves is transformed into objective information called "crisis stabilization" and "utilization management". This process alienates people who see themselves as community members and as advocates for "real people". These practices that create objective knowledge are management technologies that are designed to bring order and control and thus are ruling practices. This ruling is located outside the experience of advisory committee members and is outside of the local community. The ruling practices that transform people's experience into objective data make it difficult to implement a policy of community inclusiveness and community control.

Practices Together: Complementary Or Contradictory?

It became clear to me that the process of participation or community self-determination was structured by factors outside the experiences of people at meetings or in relationships with one another. As I examined the two sets of practices at work to influence the participation process, I recognized inherent contradictions. While facilitative practices were based on interaction and interpersonal relations, decision-making practices were based on separating interaction and relations in order to translate experience into something that was controllable and manageable. Both sets of practice were aimed at producing a certain kind of knowledge that is integral to participation and decision-making. Facilitative practices encourage experiential, subjective or what Smith (1987) calls "embodied knowing", which is the knowledge product required to support participation and community involvement. On the other hand, objective and information-based decision-making practices construct knowing in an objectified way because that is the knowledge required to enter into budget processes and bureaucratic organizations. This is particularly true in the very complex and convoluted system of both matrix and rigid multi-layered management hierarchy prevalent in mental health services. However, I also recognized that the facilitative practices, because people felt that their experiences were validated and legitimate knowledge, contributed to the acceptance of control and the continuing construction of objectified knowing. In this way people's lived experience was incorporated into the management and control mechanisms at the same time as the practices of separating experience maintained centralized control. The facilitative practices worked in conjunction with the set of decision-making practices to create the environment where community members began to organize themselves for decreased involvement in decision-making. This "knitting together" of the contradictory sets of practices as ruling relations served to keep community members feeling good, viewed as competent, but disempowered, and created an illusion of participation and inclusion. In this way, the distribution of power in the participatory process materializes through social relations.

Chapter 7

The Policy Connection: Contradictions Recreated

> " The structure becomes the superficial celebration of the ideas, which it also invariably crushes."
>
> (John Ralston Saul, 1993)

Having uncovered a set of social relations and practices or technologies that construct community participation away from community-based decision-making, this chapter will examine "Closer to Home", the current policy framework in British Columbia. This is the policy framework within which our health services, including mental health services, are currently being reorganized.

While this policy framework incorporates the ideas of participation and empowerment, it must also be recognized that one of the driving forces moving policy in this direction is the need to control costs and get the best value for the money spent. Given what I have uncovered about the relations between participation, empowerment and resource allocation and the influence of practices on participation and empowerment, this look at the policy framework is guided by my research discoveries.

Provincial Policy Framework - "Closer To Home"

A change process in health care in B.C., was brought into focus through the work of the Royal Commission on Health Care and Costs which tabled a comprehensive set of recommendations with the provincial government in November of 1991. While unanimous in their opinion that "the system of health care in this province is one of the best, and quite possibly the best, in the world" (pg. A-3), the commission observed that not all British Columbians are equally healthy, and not all have reasonable access to the health system. They endorsed the five principles of medicare: comprehensiveness, universality, portability, accessibility and public administration as outlined in the Canada Health Act, 1984 and arrived at a set of guidelines to provide a framework for the development of an overall plan for the delivery of health care services in British Columbia.

The guidelines are:

1. Closer to Home - medically necessary services must be provided in, or as near to, the patient's place of residence as is consistent with quality and cost-effective health care.
2. The Public First - public servants and professional colleges must always put the public interest ahead of their own or their members' interest.
3. Outcomes - the focus of the health care system must be on providing those services which improve health outcomes. These outcomes must be defined, measurable, subject to analysis and able to be independently evaluated.
4. Community Involvement - decisions should be made as close to the community level as possible; local people must be allowed to shape the local system of health care delivery. Government should be prepared to fund coordinators and to encourage the creation of advisory boards.
5. Funding - the people of British Columbia must reform and improve the health care system within the current levels of spending.
6. The Jericho Process - administrative walls within the Ministry of health, among ministries, health care institutions and organizations, and between all of these groups and educational institutions, must be broken down in favour of an integrated health care system.
7. Necessary Education - all tasks within the BC health care system should be open to people with the education necessary to provide high quality care. People should not be barred from performing a task because they lack education which is not necessary to performing that task and does not demonstratably improve health. The "credentialization of positions within the health care system must be stopped.

8. Volunteers - people have the right to participate directly by volunteering their time in appropriate roles. These include governance, patient service and advocacy, but not replacing paid staff.

9. Openness - except where privacy and confidentiality demands otherwise, all of the information on health and health care gathered by public servants in ministries and in publicly funded institutions should be available to the public and to researchers.

(Closer To Home; Vol. 2, Nov. 1991)

The commission identified that the traditional focus of the health care system was on the curing of illness and not the prevention of injury and disease and recommended a change in focus to spend more money on prevention and protecting health and the least amount of money possible on providing necessary high quality services.

The report states that enabling people to make their own health care decisions is indeed healthy public policy. It identifies four basic elements of public policies for health that distinguish health from other public policy arenas. They are:

1. They focus on the link between an individual's health and the social and physical environment

2. They involve many different institutions, businesses, organizations, formal and informal community networks, ministries and levels of government.

3. They use experts from many different disciplines , not just the health sciences.

4. They involve the community in developing and implementing policies to support health.

(Closer To Home; Vol. 2, Nov. 1991)

In addition the report states emphatically that " public policies for health also encourage government to be accountable for the effect of its initiatives on the health of the community it serves" (pg. B-4).

After several months of public consultation, as a result of the work of multiple advisory groups intended to involve key participants in the health care system, and in response to the Royal Commission, the provincial government released, "New Directions for a Healthy British Columbia", in February 1993, which established a new definition of health, a shared vision and common mission for the health system in British Columbia.

The definition of health adopted by the provincial government to support the vision and mission of the health system is the World Health Organization's definition developed in 1984. It is:

> The extent to which an individual or group is able, on the one hand to develop aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is seen as a positive concept emphasizing social and personal resources, as well as physical capacities.
>
> (New Directions, Feb. 1993)

The shared vision articulated in the document is one of healthy citizens and healthy communities.

> Healthy citizens are those that:
>
> take personal responsibility for good health habits. They are able, both financially and socially, to make informed and effective decisions and choices regarding their health and the wise use of the health system. They contribute to each other's well-being and to the health and quality of life of their community.
>
> (New Directions, Feb. 1993)

> Heathy communities are:
>
> characterized by local government, business, labour, and other citizens working together to identify and resolve issues affecting health. They create supportive environments for health and safety in their homes, places of employment, and recreational settings. These environments will help improve the quality of life for every individual in the community. Members of a healthy community recognize the social, ecological, and economic realities that affect their collective health and quality of life.
>
> (New Directions, Feb. 1993)

Based on the above definition of health and shared vision the mission of the British Columbia health system is established in the document as:

> To promote and provide for the physical, mental, and social well-being of all British Columbians
> (New Directions, Feb. 1993)

Having articulated the definition, shared vision and mission, the document outlines five new directions to begin the revitalization and reform of the health system. Viewed collectively, these five new directions comprise the policy framework of the British Columbia health care system. The five new directions are:

1. Better Health - Involving actions which recognize the broad social determinants of health.
2. Greater Public Participation and Responsibility - Involving actions to assist citizens in making informed choices about their own health and health care, increased public representation on professional regulatory boards, and providing more opportunities for local decision-making.
3. Bringing Health Care Closer to Home - involving actions for ensuring more local management of health services and the provision of more services in people's homes, local communities and regional areas
4. Respecting the Care Provider - involving actions to develop closer partnerships between all care providers, the government and the general public and involving them in planning health services
5. Effective Management of the New Health System - Involving actions to develop a decentralized partnership approach to management including developing clearly defined health goals supported by ethically sound, financially responsible decisions which are based on quality, appropriateness, effectiveness, equity and affordability.

(New Directions, Feb. 1993)

This policy framework is consistent with a concept of inclusiveness and provides a theoretical and ideological basis for health reform that appears to rise from a paradigm of inclusiveness. There is an underlying commitment to ensure a direct role for communities in identifying priorities and making health planning decisions which are in the best interest of the community. However, as this research has shown, facilitating and decision-making practices accomplish ruling through the creation of compliance, no matter what paradigm the policy comes from. What then does the current policy framework say about practice and the critical examination of traditional professional and bureaucratic knowledge and practice?

The 38 actions articulated in the policy document to implement the recommendations of the Royal Commission might be considered the practice framework for implementing the new vision of health in the Province of B.C. For example New Direction # 3 "Bringing Health Closer to Home" recommends a decentralized health system, both in management and service provision. The three actions proposed to implement this "new direction" include the development of:

1. Community Health Councils at the local level, whose primary responsibility initially will be planning and co-ordinating health services, and identifying local health priorities. Over time, these councils will assume responsibility for integration and management of services now delivered by the Ministry of Health, hospitals and health provider organizations and resource allocation for the health services in the community.

2. Regional health boards, composed of representatives from community health councils and individuals appointed by the Minister, whose initial role will be regional health planning and service co-ordination. This will be expanded in the future to include allocation of a regional global budget. The budget will include funding for services delivered by the Ministry and those provided by hospitals and other agencies funded by the Ministry.

3. A restructured Ministry of Health that provides support to regions and communities. It will be responsible for distributing equitable funding to regions, establishing

> provincial policies and plans, setting standards, monitoring outcomes, and carrying out evaluation.
> (New Directions, February, 1993)

While this "new direction" identifies a structure for local management and talks about restructuring the Ministry of Health to support communities and regions, the document does not identify specific bureaucratic and professional practices. This has a very familiar ring to it, in that this same emphasis on structure and same lack of emphasis on activities and practice is what I identified in the original contract with Ministry of Health, Mental Health Services describing the development of a mental health advisory structure. I discovered that the best intentions for inclusion got transformed by traditional bureaucratic and professional behaviour. If these practices have the potential of compromising the best-intentioned participation and empowerment policies, does this policy initiative not demand a shift in public administration and professional ways of knowing and practice? Where in this framework is that shift identified or supported?

In the New Directions document, in the section on effective management (pg.18), it would appear that time-honoured and prescriptive technologies regarding accountability and evaluation are being rigidified rather than being examined critically in relation to the shift that is being aspired to. For example, priority actions in this section include:

> Informed decision-making, clear accountability, careful spending, and greater public participation all require comprehensive and responsive **information systems.** Specific initiatives include:
> a) new standards and protocols will be developed for the collection of information and for gaining access to the information system. This includes the continued development of a "severity-based" medical management

> information system in hospitals. This will provide comparative information on appropriateness, quality of care, and outcomes of care, to physicians, hospitals, government, and the public.
>
> (New Directions, Feb 1993 pg. 19)

As was demonstrated with the experience of community decision-making, the practice of developing standards and protocols and then transforming the real experiences of people into data that an information system can accommodate has the potential of distancing and distorting the very real issues of the community. The issues get transformed into an objective report on appropriateness, quality of care etc. and may obliterate rather than enhance informed decision-making and public participation.

While accountability is unquestionably necessary to ensure that the greatest value is derived from each tax dollar, the definition of accountability and practices appropriate for evaluating and achieving accountability in a community-based model of health care may be very different from those appropriate to a hierarchically and professionally structured organization. Accountability has come to be synonymous with notions of cost-benefit and is seen as a solution to the problem of scarcity of resources and the competition for health care dollars. However, to community members and frontline workers the notion of accountability is much broader. In addition to cost-effectiveness accountability also means a host of other things, such as responding to the needs of the community or client, respecting client's wishes, working respectfully with colleagues and maintaining standards of practice. Of course, these "other" views of accountability also get transformed through objective practices in organizations and distance experience. The paradox is that in order to achieve accountability and deal with the problem of cost containment and scarce resources, we must achieve community-based decision-making. The solution to the problem is not in more rigidified systems but in truly giving voice to the strong grass roots interest in community control. How will we do that without examining and changing practices and questioning time-honoured technologies and the beliefs that underlie current practices? It is my view that careful examination of current accepted norms of practice need to be incorporated into actions if a health system responsive to the needs of people for adequate health resources and cost containment is to be achieved.

Another example in the document involves the development of evaluation information.

> With increased emphasis on accountability, it is necessary to focus more on evaluation of outcomes rather than on process and control. Specific initiatives will include the following:
> a) standards and models for evaluation of outcomes will be established
> b) evaluation and utilization management mechanisms will be made mandatory for all agencies receiving government funding.
> (New Directions, Feb 1993 pg. 19)

Within a framework that values input based on experience, not credentials, for instance, practices of evaluating and setting standards objectively must also be questioned. These techniques are the forms of knowing and acting that credentialed professionals understand and pay homage to. Non-credentialed people speak, know and act from an entirely different basis. The act of separating the subjective experience is inherent in evaluation mechanisms. If these evaluation methods are to become mandatory, credentialed professionals and bureaucrats will continue to have the upper hand and we will have not achieved the shift of power represented in participatory and empowerment vision. The question remains - "how do we need to practice in order to ensure outcomes that are integrated and complementary to people's experience not separated from it?" There is no provision in the document for examining practices critically in order to bring management (ruling) practices into line with the new policy.

Discussion: Shifting Paradigms And Practice

The principles underlying the change process in health to inclusion and participation are not unique to health reform but rather are part of the larger evolving change process in our social, political and economic environment. The introduction of health promotion concepts, the adoption of a broader definition of health that includes a wellness philosophy and a greater recognition that clients are able to make decisions and act as partners with professionals in the decision-making process about their health are part of this change in the health system.

This evolutionary change process represents a paradigm shift in governance. The two sets of practices uncovered in this study are based in very different paradigms of action. Facilitative practices which encourage inclusion of communities and consumers as co-planners and policy makers in human services reside within an inclusive paradigm that is characterized by the valuing of self-responsibility, shared expertise, contextually defined experiences and multiple realities. Conversely, the existing decision-making practices such as those found within large bureaucracies embrace traditional tenets and practices which arise from a technical-rational paradigm that is characterized by values embedded in rationality, logic, objectivity, a single truth or right way, categorization and the value of experts.

While recognizing the paradigm contradictions, the study has shown how the two sets of practices work together as ruling practices to create structural and experiential constraints to community self-determination and control and ultimately create compliance and organize community participation to maintain the status quo and support the traditional paradigm. Power arises from the "rule of law" or the state's mandate to rule and is supported by and supports the ruling practices embedded in public administration. In addition, it has identified discourse and documentation in health policy and practice frameworks that maintain the status quo by maintaining the invisibility of the need for a shift in bureaucratic and professional practice complementary to the paradigm shift to inclusion and participation.

The paradigm which gives rise to current decision-making practices in bureaucracies has been widely and unquestionably accepted over the past century. Critical evaluation has not been invited nor seen as useful. The limitations, because of its integral role in the legitimacy of ruling in liberal democracies, therefore, have neither been widely exposed nor critiqued. Because of this, many practices within our modern systems based in this paradigm remain unexamined.

Kuhn (1970) states the period of transition from one paradigm to another reaches a crisis and is characterized by confusion, insecurities and a proliferation of differing views and theories. Gradually, the resulting transfer to a new paradigm is achieved and people respond to a different world as a result of perceptions having changed. After a paradigm shift, many former manipulations and measurements become irrelevant and are replaced by others.

Using Kuhn's (1970) model of scientific change, Kleffel (1991) states that when facts can no longer be explained by the paradigm or when the paradigm no longer provides model problems and solutions, an anomaly exists. Discovery begins with the awareness of the anomaly. When the anomalies which subvert the existence of the paradigm can no longer be ignored, innovative research and policies arise which bring a new basis for practice.

It would appear that within the evolutionary change process in health the awareness of an anomaly is becoming more and more evident. My research however, raises the question about whether this awareness is bringing about a new basis for practice and a shift throughout the system or whether practices arising from the inclusive paradigm are becoming part of the ruling apparatus to maintain the status quo?

Chapter 8

A Final Word: Community Participation And Analysis

In February 1993, I met with the mental health advisory committee for the last time. At that time, I presented to them my argument and a summary of the analysis. I made visible for them how the acceptance of non decision-making had been constructed and they immediately:

a) recognized it as their experience

b) expanded on the analysis and proposed that the two sets of practices were gendered. They thought that facilitative practices might belong in the world of women and decision-making practices belonged in the world of men. They also suggested that this analysis might be considered an extension of the patriarchal society and the power differentials between men and women inherent in society.

c) began to assess their responses to decisions and changed how they responded. Clearly, they were no longer going to quietly accept non-decision-making.

Also on the agenda that day, was a discussion about the impending resignation of the Director of the Centre. The advisory committee immediately began to plan how they could not only give input on the selection of a new director but be an ongoing part of the process. They drafted a letter to the Regional Director outlining a process whereby they would be involved in the drafting of a job description, short-listing, interviewing and selecting a new Director. They did not ask permission nor did they ask for an opportunity for input and wait for his suggestion regarding how they might be involved.

Ultimately, the analysis enabled the advisory committee to see how control mechanisms work to constrain their input and allowed them to assess their responses in order to more effectively work towards community self-determination.

I learned from this example how the participatory research process works. The community participation in the research and discussion of the analysis uncovered for them and me something that was out of our grasp before we began the research. Having uncovered that information and made the link our ability to respond and our behaviour changed. My understanding of participation and empowerment and my practice has changed as a result of this research. The community group's understanding of participation in decision-making has changed and they behave differently. Consciousness raising has been accomplished and I am confident will be built upon as both I and the community group continue to add our experiences to this analysis. The research has already been useful and has in a small way moved us closer to participation and inclusion in health and health care.

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Appendix A

OUTLINE FOR RESEARCH PROJECT

Researcher: Mary Elizabeth Tate

As many of you know, in addition to assisting in the facilitation of this process to develop community based advisory groups, I am also completing my studies towards a Master's degree in Policy and Practice 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 my thesis. My research interest is the involvement of community members in the development of policy and I would like to suggest that we discuss the possibility of engaging together in not only the development of the advisory group in relation to mental health services in the region but also research about how the process "works". Obviously this will help me in that I will collect data for my thesis, but I believe it will also enhance the process we are engaging in and will also provide us with some direction for not only this process but for future participatory processes.

This will involve a research process where we collectively investigate:

1. what the barriers are to the advisory committee participating community-based decision-making
2. how the advisory committee structures and organizes itself in order to have a voice and overcome the barriers.

The goal of this research process is to understand the process we are engaged in and act to change it or create something new. The process is three-fold and cyclical; (1) collective problem-posing and investigation (2) collective analysis of the problem (3) collective action taking to address problem. I see this process as the same as the process of facilitation of the development of the advisory group. We will be collectively investigating, analyzing and taking action to create a structure to achieve much fuller community involvement in the planning and delivery of mental health services. An integral part of the analysis will be how the advisory group structures and organizes its interaction in this process. Without this analysis, the creation of meaningful participation by the advisory group will be very difficult and for this reason, I believe this analysis is also integral to the facilitation process.

The research is independent of both my employer and the Ministry of Health, Mental Health Services, although both parties are fully informed and have given agreement to me to access data from the process of development of advisory groups.

The data collection would include fieldnotes and taping of our meetings and interviews with participants in the process. I would like to discuss the parameters of participation and how people would like to give permission or be included. If people agree to interviews, these will be arranged individually and separate consents will be obtained (see attached). The participants at the meeting will not be identified and the results of the study will in no way identify them. Participants will be free to withdraw at any time by contacting me and informing her that they do not want certain aspects of the meeting or interaction used as data. Any tapes recorded will be identified by number and date and will be destroyed after the research is completed.

Drafts will be shared with participants and will not be considered complete until participants are satisfied it reflects their experience.

APPENDIX B

INTERVIEW CONSENT FORM

Investigator: Mary Elizabeth Tate

I, ____, consent to participate in the study to examine involvement of consumers and community members in processes to plan for services and develop policies that affect them.

I understand that my involvement in the study is completely voluntary and that I may decide to withdraw at any point without negative consequences.

I am aware that I will be interviewed by the researcher and asked a series of questions relating to my experiences in the process of developing advisory groups to mental health services. I may be asked to participate in an interview on more than one occasion and these interviews will be tape recorded and the information on the tape will be destroyed after the research is completed.

I am aware that my involvement in this project will be kept strictly anonymous by the researcher, and that the results of the study, published or unpublished, will in no way identify me.

If I have any concerns about the conduct of the research or the researcher, I can contact the researcher at 383-6166 or her Supervisor, Dr. Marie Campbell, at the University of Victoria, 721-8203.

Signed: ________________________________

Date: ________________________________

VITA

Surname: TATE Given Names: MARY ELIZABETH

Place of Birth: Vancouver, B.C. D.O.B.: January 30,1949

Educational Institutions Attended:

Royal Jubilee School of Nursing	1967 to 1970
University of Victoria	1979 to 1982

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Honours and Awards:

Dean's Scholarship	1992

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Title of Thesis:

THE ILLUSION OF INCLUSION:
An Analysis of Participation, Empowerment and Community-Based
Decision-Making in Mental Health Planning

Author [redacted]

MARY E TATE

Sept 29/93