**Navigating The Implementation of 'New Directions' in a Region of British Columbia: Who's at the Helm?**

**A Study in the Social Organization of Knowledge**

by

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We accept this thesis as conforming
to the required standard

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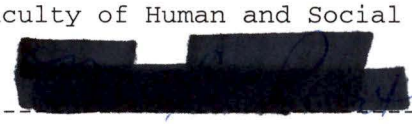

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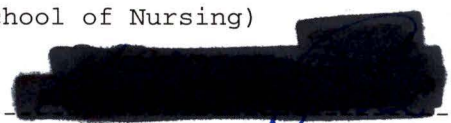

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**ABSTRACT**

This thesis examines the implementation of a distinctive form of health policy in a region of British Columbia in the early 1990's. This policy mandates the involvement of citizens in health policy planning and implementation. The study asked, "through what opportunities (activities, decisions) can/does the Regional Health Board establish regional priorities, objectives, and plans in order to develop a regionally-defined character for health care? and "how does this policy get put into practice through everyday activities of real people?". The study uses data gathered as a community attempted to implement an innovative health policy "New Directions" through the development of a regionalized health planning body (a Regional Health Board) and using community development with its inherent emphasis on citizen participation as its major strategy. The experiences of staff and trustees of the Regional Health Board as they attempted to negotiate a local priority, the transfer of direct responsibility for mental health services and programs from the Ministry to the region, have been examined using the qualitative methodology called institutional ethnography. In this analytic method, the experiences of those trying to implement a locally-responsive form of health planning become the entry point for explicating the wider web of social relations which shape these experiences. The study argues that the "New Directions" focus on citizen participation motivated at least in part by contemporary fiscal difficulties took a different direction than the community-held view of participation which was informed by principles of

community development. The approach to implementing policy through citizen participation taken by Ministry officials, on the one hand, and citizens working in conjunction with the Board trustees and staff, on the other hand, were quite dissimilar and incongruent. Each group failed to see that they both were working according to a set of practices that was congruent with their different approaches. This research offers insights into how the new managerial technology of more participatory administration disrupts conventional public administration practice, but does not alter the exercise of centralized power, even in the more decentralized state organization which was being put in place through this policy and related Ministry practices.

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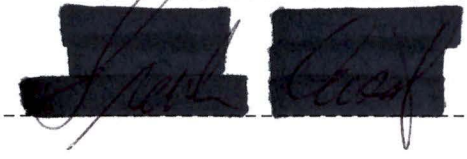

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A special thanks to my many friends and colleagues who provided helpful encouragement (and occasionally, a shoulder to cry on) during the course of this research and writing.

Lastly, I wish to voice my heartfelt appreciation to the trustees and staff of the Regional Health Board, who willingly gave their time and shared their experiences with me during the time period of this research.

## DEDICATION

I dedicate this thesis to my daughter, Ramata Tarawally, who has grown to be such a lovely person, and who adapted so willingly to the many changes that my entry into graduate education required of her.

# INTRODUCTION

In the province of British Columbia health care has recently come under intense examination. In 1991, the Royal Commission's Report on Health Care and Costs, "Closer to Home", was released. In 1993 the provincial Ministry of Health responded with the document "New Directions" which recommended major changes, including the decentralization of health care through the creation of local and regional health boards, the fostering of community participation processes in decision-making, and the shifting of services from acute care to the community. Regional Health Boards would be developed, intended to play a key role in building the new partnerships necessary for both the restructuring of the health care system and the process of community consultation or participation.

This study is about the attempt by one such Regional Health Board to implement "New Directions'" public participation focus. The Regional Health Board and the Ministry of Health each developed ideas and practices which they felt were compatible with public participation. However, I discovered that these two players, the Regional Health Board and the Ministry of Health, developed different and incompatible working practices in their attempts to implement citizen participation. While the outcome of the recent initiatives may indeed be more citizen participation, I argue that the community-held and governmental views and practices of participation are contradictory. In this study, participation by citizens was being called upon as a new health reform strategy, yet the "ruling" practices of government were being maintained by the Ministry of Health.

In order to provide the background and context of this study, I have provided two further sections in this introduction. I begin by presenting this study's problematic and my relationship with this research. Later in the introduction, I describe the current Canadian context of health care reform, highlighting the "New Directions" policy initiative in British Columbia.

## Research Problematic

*"The term "problematic" enters an actual aspect of the organization of the everyday world (as it*

*is ongoingly produced by actual individuals) into a systematic inquiry." (Smith, 1987, p. 110)*

The government of British Columbia, in deciding to introduce the reforms outlined in "New Directions", has made a significant shift in policy. By mandating the authority of regional boards (through Bill 45), the Ministry of Health has made decentralization and regionalization their official policy. Regionalization is then to become practice, implemented locally by regional health boards and through the use of strategies such as community development.

Community development is a topic of much interest to me, since as a nurse and a feminist, I have frequently described my front-line work as involving "community development". One such project involved working in the downtown core of Toronto, with people who are homeless or inadequately housed. During a period of approximately eighteen months, I "pounded the pavement", seeking out people experiencing homelessness, in places where they felt safe, and hence congregated. I committed myself to listen to what homeless and underhoused people had to say about their health, health care, my organization, and factors which affect their health or access to services. Over time, my thinking subtly shifted as I began to really hear the "voices" of the marginalized people I had come to know. This shift was not only a personal recognition of inequity. I began to understand what marginalized people were saying about barriers to accessing care, and about health care that was not responsive or appropriate to their needs.

As my understanding grew, so too did my realization of how the health care system in general, and my organization, specifically, participated in setting up barriers, both to clients and to the process of community development. I found myself at odds with other front-line staff and the management of my organization as I attempted to re-orient my workplace to my new understanding. I recall a staff meeting where this became particularly apparent. As a staff we were talking about setting up "drop-in" times to accommodate people who needed more immediate care through the community health centre. This was an important move in my organization, in terms of reducing a significant barrier to access for people who are marginalized. I explained my understanding of the importance of this change for people who are homeless. A colleague countered by asking me why I thought "those people" should be given such

"privilege" and I recall my shock and dismay. Eventually, I understood that I was at a different place of understanding than many of the other workers in my organization. This different place stemmed from my community development ideas and my attention to the "voices" of people who are marginalized.

However, through this experience, I also gained a glimpse of the organizational and systemic constraints which make community development work so complicated. A number of the health care providers in my organization were frustrated at the idea of "drop-in" times for homeless people as it might upset the management of their daily workload. The organization had to account (to the funder - the Ministry of Health) for the paid time of each staff member, and health care providers completed "encounter" forms to describe their work with clients. The encounter form data provides a way of looking at the health care provider's time allocation in relation to client information (client diagnoses, types of assessments, and treatments). Moving to a system of "drop-in" (rather than booked time) had the potential of upsetting the workload management, as clients might show up during the allotted time, if they required care, or they might not. If there are few or no clients at any particular time, this would play havoc with the rationalization of staffing, as it would become difficult to explain to the Ministry of Health why salaried employees are not "encountering" clients during paid time. Of course, this takes no account of the benefits that homeless and underhoused people might experience as a result of accessible "drop-in" times.

This experience also highlighted the issue of the locus of decision-making authority. Initially, it appeared as though the position of the organization's physicians (who were uniformly against a change to "drop-in" times) would prevail. However, the organization's Board of Directors quickly made it known to the staff that they expected that the needs of homeless and underhoused people be given priority. After this intervention by the Board, "drop-in" time became a reality.

These experiences gave me a personal understanding of the attitudinal, organizational, and systemic barriers which can hinder the process of community development and, as a result, prevent real change. The practices of community development in my agency exposed for scrutiny the systematic barriers to change in the locus of power, and provided opportunities for observing how individuals within

organizations enact such practices. However, I also recognized that through community development, there was a challenge to the traditional organizational exercise of power.

A puzzle emerged as I brought my personal experiences of "disjuncture" to this inquiry into community development as a strategy for governing. Would these kinds of barriers emerge in the Regional Health Board's attempts to implement regionalization and public participation through community development? And if so, in what forms?

## Canada's Health Care System

Canada's health care system has been described as emerging within a "loosely coordinated legislative framework" with a "network of structural and financial controls" (Charles & Badgley, 1987, p. 61). The legislative framework includes such cornerstones as the British North America Act of 1867, which designated health care as primarily the responsibility of the provinces; the federal Hospital Insurance and Diagnostic Services Act of 1957, which provided public funding for hospital services; the Medical Care Act of 1966, which provided public funding for medical or physician care; and the Canada Health Act of 1984, which replaced the earlier acts, and was intended to clarify and strengthen the Medicare system (Badgley, 1987).

The national Medicare program includes a number of Federal funding eligibility criteria, including public administration, portability of benefits, provision of comprehensive services, reasonable access to insured services, and universal coverage. In 1977, the financing of health care was changed from a cost-sharing formula to a block-funding arrangement, in the form of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, the EPF Act. This act set out a financing agreement, with per capita block grants linked to population growth and GNP, and equalization payments for poorer provinces. It also allowed the federal government to reduce equalization and EPF payments to the provinces by the mid-1980's. At the same time as the federal government began reducing funding for health care, it proclaimed the Canada Health Act of 1984 "to reassert the federal presence in the domain of national health insurance and to assure that the standards set were adhered to by the provinces"

(Badgley, 1987, p. 60). In 1996, the federal Liberal government introduced the Canada Health and Social Transfer (CHST), a 5 year federal-provincial/territorial financial arrangement for the funding of health and social programs. Yet again, while reaffirming their commitment to the principles outlined in the Canada Health Act of 1984, the government set out a further reduction in federal payments (of some 40%) through the CHST.

## Health Care Policy in Canada

Health Canada (formerly the Department of National Health and Welfare) is the Federal Department responsible for national health policies. Provincially (and Territorially) there are Ministries of Health, responsible for the management of the provinces' health care systems. Each province and territory has formed a unique system of health care, comprising acute hospital care, chronic or long-term care, medical services, community or public health care services, home care services, drug benefits or pharmacare, ambulance services, and in some cases, alternative health care modalities.

Evans (1992) draws attention to the ability (extended through Medicare) of making "choices" in the Canadian health care system, noting that while "health insurance in Canada is socialized, care is not" (p. 739). People can exercise choice in terms of primary care physician, and perhaps, in terms of specialists or hospitals. These "choices", however, may be limited by availability or geography. For example, while many primary care services through physicians are funded in the Canadian Medicare system, the same or similar services through alternative practitioners (such as herbalists, nurse practitioners, midwives, or naturopaths) are not included in all provincial medical services plans. Hence, although Evans' assertion is accurate that health care is not socialized (as is health insurance), provincial governments set out the "choices" that people can make within current public funding arrangements.

## Health Reform in Canada

In recent years the issue of health reform has been the subject of intensive debate. Since 1987, nearly every Canadian province has held a commission or review of its health care system. Issues in the

debate include: the nature of "health"; the locus of health care planning and decision-making; access to, and appropriateness of, health care services; and sufficiency of current funding levels.

Mhatre and Deber (1992) argue that Canadian policymakers believe that there is equality of access to health care, but not equity of access to health, and, as a result, have turned their attention to this latter point. They build this argument based on their examination of recent provincial health commissions and reports, noting the following recurring themes; broader definitions of health, a shift from curing illness to promoting health, a switch from institution-based to community-based care, demands for public participation in decision-making and decentralization to regional authorities, interest in improved human resources planning and alternative remuneration of physicians and for more efficient management of the system.

However, Mhatre and Deber note the increasing interdependence of health care policy with social, economic, environmental and political spheres and the recent focus on the finite nature of fiscal resources. They wonder whether it will be possible to achieve the reforms and changes being suggested in provincial commissions and reports.

Evans (1992) also notes the recent attention in Canada to equalizing access to health, and the relative success that Canada has had in containing health care system costs, especially when compared with the United States. While Evans is also concerned about limited financial resources, he argues that the real issue in Canada is how to improve the management of the "popular, effective, and heretofore affordable system, so as to preserve it in a more hostile economic environment" (p. 739).

Rachlis and Kushner (1989, 1994) argue that more could be accomplished with the present level of funding if the system were structured differently. They want to see a new emphasis on primary care reform and new regional governance structures. Inherent within these ideas is the notion of public participation in the planning of regional or local services, and a broader view and definition of health. Restructuring and improvement of the system, they argue, could be done within existing financial resources.

In the literature outlined above, a picture of Canadian health care reform emerges, with changes

and improvements to the management of health care, broad definitions of health, public participation in decision-making, and a shift from institutional to community care.

## Health Care Reform in British Columbia

> *"Renewal of British Columbia's health system depends on our collective ability to create a sensible plan to move us into the twenty-first century. We need to build new partnerships that bring together clients, health care workers, business, labour, communities, the general public, and the various levels of government"* (Ministry of Health, and Ministry Responsible for Seniors, 1993, p. 1).

The "New Directions" policy of health care reform originated from the Royal Commission on Health Care and Costs, which outlined the need to get full value for every health care dollar spent in British Columbia (Campbell, 1992; Ministry of Health, 1993). Hence, while "New Directions" literature outlines a regionalized, decentralized health care system, it also contains a discourse of accountability, improved public administration, equity and democracy.

Community development and public participation are outlined as potential implementation strategies, anticipated to result in "partnerships" in health care planning and decision-making. The aim is "health" (broadly defined)[1] so that healthy citizens and communities result from the local (hence, more appropriate and responsive) health care planning process and decision-making. The "New Directions" vision of health care reform includes a re-commitment to the principles of Medicare (universality, comprehensiveness, accessibility, portability, and public administration) and an acknowledgement that "health" must be addressed in a comprehensive, effective and integrated manner.

Reform strategies include the establishment of community health councils and regional health boards, restructuring of the Ministry of Health, and the development of enabling legislation to legitimize the transfer of authority from the Ministry to community health councils and regional health boards.

In Chapter One of this thesis, I conceptualize the inquiry, exploring the ideas and literature underlying "New Directions'" explicit public participation focus. I began by examining concepts including health, health promotion, community development, participation and partnership. As I probed

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1 Interestingly, the Royal Commission resisted the World Health Organization definition, preferring a more traditional concept of health. The Harcourt Government, by contrast, embraced this wider view.

the literature which speaks to these concepts, I discovered that much of what is written about these concepts takes for granted their contemporary usage and inherent goodness. Much of the feminist and critical literature pertinent to these concepts examines power and power structures, and the need for significant and real power shifts or re-structuring for ideas such as "participation" or "partnership" to occur. I then examined the literature which identifies power as central to its critique, finding a number of different notions of power. Dorothy Smith's notion of power, as exercised through social relations, and as a part of "ruling relations" resonated for me, forming the lens through which I conducted this research. Finally, I sought out management and administration literature, recognizing that applying "New Directions" means moving policy into practice. In these bodies of literature, concepts such as policy implementation and administration had a curiously disembodied nature, as I was unable to discover human agency or action in "doing" policy. This led me to the work of feminists who have critically analyzed management literature, building compelling arguments of modern bureaucracy as a "management technology", and of public administration and management as forms of "ruling" relations.

In Chapter Two, I outline the methodology which I chose for this research, institutional ethnography, and its origins in a social construction of knowledge approach. Institutional ethnography, developed by Dorothy Smith, is an approach which seeks to explicate "how things work" through analyzing the social relations which shape what happens, but which are not readily visible. This form of analysis allows the researcher to examine the social relations from a particular standpoint, in the case of this research, from the point of view of trustees and staff of the Regional Health Board as they tried to implement "New Directions" locally. I found this approach particularly valuable, as this analytic attention to "how" things work as they do, enhances the understanding of the researcher and of those whose side has been taken, and of how local events are shaped by extra-local forces.

In Chapter Three, I begin my data analysis with an overview of the mental health transfer process in British Columbia. I present a version of mental health-related historical events, showing how the Regional Health Board decided to formally link the local mental health transfer process with "New Directions". I also introduce the "New Directions" policy, and its explicit participation focus.

Throughout Chapter Four, I show the different ideas and practices of the Regional Health Board and the Ministry of Health, as they each went about implementing New Directions. The Ministry of Health restructured its organization and continued to think about and develop practices for participation which were compatible with its underlying public administration focus. The Regional Health Board interpreted public participation through its community development framework, developing practices and ideas compatible with its interest in locally responsive planning. I argue that the ideas and practices developed through these competing frameworks are inherently incompatible.

In Chapter Five, I conclude my data analysis by examining the different ideas and practices around "co-management", a central aspect of the mental health transfer negotiation process. I use the co-management documents, one set developed by the Regional Health Board, the other by the Ministry of Health, to show how the Board's planning was locally relevant, while embedded within the Ministry's documents were extra-local relevancies which had very little to do with the Board's attempt to negotiate local control over mental health. In the end, the Ministry of Health maintained its locus of control over the mental health transfer negotiations.

# CHAPTER ONE

# CONCEPTUAL FRAMEWORK

The documents that establish "New Directions" as an implementable policy contain references to a variety of new ways of working, as well as new goals for health care administration in the province. In this section, I conceptualize my inquiry, and explore concepts such as health, regionalization, decentralization, community development, partnership, participation, management and public policy implementation.

## Health

The health reform being promoted in British Columbia rests on a particular definition of health, described as "health in its broadest context". The concept of "health" has been reworked in recent years, from a definition limited to the absence of disease, to one including notions such as the "social determinants of health", and health as a "resource" for everyday life. These various and disparate views of "health" can be linked to professional, paradigmatic and political interests.

Early definitions of "health" as the absence of disease are associated with the medical model, and with physician-determination of disease (Rachlis and Kushner, 1994). This definition of health has often been criticized by non-physicians for its narrow focus, and "all or nothing" limitation. Physicians and medical science became the purveyors of "health" with the ability to define disease, and in its absence, health. Views of "health" using different descriptors or comparisons emerged. Hence "health" was often described as resting somewhere along a continuum with illness or disease juxtaposed with health.

This narrow definition of "health" based upon the absence of disease originates within a view of science as paramount to the practice of medicine. Within this paradigm, diseases are scientifically identified and cured. In recent years, as the paradigm of science (and technology) has been challenged, there has been interest in exploring health from other perspectives or worldviews. Concepts such as the "social determinants of health" (adequate income, shelter, employment, peace, etc.) and solutions such as

alternative medicine have been developed in recognition of health as contextual.

Professions other than medicine have developed particular views of health based upon professional interests and health care reform movements. Nursing has identified with concepts such as broadly defined "health", "health promotion" and "primary health care" pursuing them for their potential to take nursing further out of the control of medicine (CNA, 1992). More recently, some nurses have begun to identify with feminist analysis of the patriarchal structure of the health care system, again recognizing the value of disassociation from medicine (Keddy, 1992).

Feminists have contributed to broader notions of health through challenging the hegemony of medicine. Feminist theorists and activists have encouraged women to reclaim their bodies, to define their own "health", to participate in identifying their issues and problems, and to choose their own solutions (The Boston Women's Health Book Collective, 1992). The "Right to Choose" movement, the "Disability Rights" movement, the "Right to Die" movement and the "Psychiatric Survivor" movement are all examples of challenges to traditional views of "health" and health care.

## Health Promotion and Primary Health Care

As professions have identified themselves with different notions of health, so too, have organizations. The World Health Organization (WHO) is such an organization, adding authoritatively to the discourse on health, and developing new health-attaining strategies and reforms, such as primary health care and health promotion. Like the newer definitions of "health", health promotion and primary health care have become part of a professional discourse. Both health promotion and primary health care have been described as arising out of social change movements, with the former being identified more with industrialized countries, and the latter being associated with struggles for social justice in developing countries. With its contributions to the conceptualization of both primary health care and health promotion, the WHO has seen its spheres of influence increase significantly, particularly in light of their post World War II disastrous attempts at malaria and mosquito control (New Internationalist, 1994).

Health promotion is "the process of enabling people to increase control over and to improve their

health, through actions associated with building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services" (WHO, 1986, p. 425). However, as Hayward, Ciliska, Mitchell, Thomas, Underwood, and Rafael (1993) note, health promotion has frequently been associated with individual "lifestyle" choices or as a set of strategies to induce "healthy" choices. Hayward et al (1993) describe health promotion as "political" when terms such as "empowerment" or the "determinants of health" are considered part of its definition. For example, when adequate income is described as a necessity, a "determinant of health", then it may be seen that providing and maintaining adequate income for everyone requires a redistribution of resources and capital.

The concept of primary health care gained prominence following the 1978 WHO Conference on Primary Health Care at Alma Ata (RNABC, 1990; CNA, 1992). It was described as a "system of health care", an "over-riding philosophy", and as "essential health care made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford" (CNA, 1992, p. 1).

Primary health care is built upon a number of principles, including "accessibility (to health care services), public participation, promotion of health and prevention of illness, intersectoral cooperation, and appropriate technologies" (CNA, 1992, p. 1). It incorporates services which are promotive, preventive, curative, rehabilitative, and supportive. Primary health care embraces health promotion and is a "socio-economic or a community development approach to health care" (CNA, 1992, p.2).

As I have noted earlier, the profession of nursing has been especially quick to embrace the concept of primary health care. The Canadian Nursing Association advocates health care reform through primary health care, and states that "nurses have a key role to play in primary health care as individuals and as members of an interdisciplinary effort to make primary health care a reality in the future of this country" (CNA, 1989, p.x). The Registered Nurses Association of British Columbia (RNABC) also advocates health care system reform through primary health care (RNABC, 1990). Both the CNA and the RNABC have recognized that there may be advantages, such as increased autonomy for nursing in

advocating primary health care as a nursing-sponsored professional discourse[2].

While the "New Directions" literature defines "health" broadly, and includes many of the concepts outlined above, such as "social determinants of health" and "community development", it is not clear whether and how these concepts will become actual practice.

Decentralization and Regionalization

The Ministry of Health states that one of the goals of "New Directions" is to "decentralize decision-making by developing community health councils and regional boards" (1993, p. 3). While the "New Directions" documents do not define either decentralization or regionalization, they do describe the ways that these notions have affected, or might affect, decision-making. The implication is that centralized decision-making (i.e. by senior bureaucrats or politicians) has frequently resulted in inappropriate or inflexible decisions, which have adversely affected local or regional health services (Ministry of Health, 1993). Conversely, it is also implied that decentralized decision-making, at the regional or community level, will result in decisions which are locally appropriate and responsive (Ministry of Health, 1993).

The discussion of both terms - decentralization and regionalization - rests on the notion of "centralized" government, where centralization refers to the locus of control of the central government (federal or provincial), and its ability to formulate, determine and execute public policy. In the field of public administration, the primary sources of strength within a strong state are described as "centralization, committed and determined cadres of administrators and financial resources" (Pal, 1992 p. 103). As a result, many public administrators describe the Canadian "state" as relatively weak, given the strength of provincial mandates, and current fiscal restraint (Pal, 1992).

Pal does concede, however, that citizens may not view the Canadian state in the same way. Many ordinary Canadians advocate decentralization, arguing that both federal and provincial

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2 It is unlikely that the professional literature will offer direction for action - given its propensity not to theorize power. See M. E. Purkis (1997) in "Canadian Journal of Nursing Research".

governments have too much control. This sentiment appears to be informing the provinces, as a number consider regionalizing aspects of government (i.e. health care ) within their control. An interesting dilemma arises. Policy is formulated and sponsored by government, and put into effect by public administrators. If public administrators view "centralized" provincial or federal governments as a source of strength, how will this affect regionalization and decentralization, when they are asked to implement regionalization and decentralization policy, and hence, by implication, "weaken" the state?

Decentralization is a trend in Canada, (Department of National Health and Welfare, 1993) as well as other jurisdictions, including Australia (National Health Strategy, 1993) and the United Kingdom (Community Participation Group, 1991). This move to decentralized structures appears to have been informed by the critique of centralized governing structures as able to make decisions which are appropriate for all communities and regions. Decentralization is anticipated to match the "task" with decision-making powers, while ensuring that planning occurs close enough to the location of the issue in order to be efficient and flexible (Department of National Health and Welfare, 1993). Yet, "decentralization", which has come to be identified with democratic participation, has a number of possible interpretations, including deconcentration, devolution, delegation, and privatization (Department of Health and Welfare, 1993; Norris, 1993).

Deconcentration is usually described as the geographic dispersal of state activities, from central to peripheral government. Devolution is the transfer of political authority from one level of government to another level of government. Delegation is the transfer of defined managerial functions within an organization. Privatization is the transfer from any government to the private sector. While these interpretations of decentralization all contain the notion of a transfer of decision-making **authority** closer to a "public", there are differences.

Regionalization is described as occurring when "the centre adapts its policies, plans, and programs to consider the special characteristics of a region" (Department of National Health and Welfare, 1993, p.5). In the public administration literature, regionalization conceptually includes the decentralization of authority and power (Department of National Health and Welfare, 1993; Pal, 1992).

There is the assumption that as a region gains authority in decision-making, the centre's control and power is automatically lessened (Pal, 1992; Department of National Health and Welfare, 1993). Missing from this body of literature is an analysis of the actual shifts in power and control that occur as regionalization and decentralization are implemented.

As was noted in a 1993 publication which arose out of a federal meeting on new management approaches in health care, much of the literature on decentralization and regionalization is devoid of an analysis of its "taken as good" nature (Department of National Health and Welfare, 1993). It is assumed that decentralization results in empowerment, responsivity, equity, integration, cost-effectiveness and health (Department of National Health and Welfare, 1993; National Health Strategy, 1993; Ministry of Health and Ministry Responsible for Seniors, 1993). The body of literature which raises questions about decentralization and regionalization examines topics such as the potential for conflict and boundary disputes to arise, whether integration and cost-effectiveness actually result from decentralization (Department of National Health and Welfare, 1993) and the potential for off-loading of responsibility without sufficient resources (Boudreau, 1991).

The "New Directions" documents, like much of the available literature, reveal the "taken as good" notion of decentralization and regionalization. The abstract and conceptual nature of the terms of decentralization and regionalization are assumed to be understood as having the same meaning for all. A number of questions arise, including how decentralization and regionalization will be implemented by people having very different, perhaps antithetical, views. Despite this potential dilemma, the "New Directions" literature considers public participation to be a key strategy in the realization of regionalization.

## Community

Community development was identified by the Regional Health Board in this study as an approach which would lead to public participation in decision-making and local or regional planning. Much of the literature on community development rests on similar ideas of community.

In stating that "community is an elusive entity, difficult to define" Dominelli (1990, p. 2) introduces us to the idea that community is another abstract and taken for granted term. However, many theorists, writers, community workers and politicians have tried to define it. Dominelli (1990) notes that Bell and Newby uncovered some 98 definitions of "community" in a study of this topic in 1971. A great number of these definitions contained a common characteristic of geographical space, and the interaction of people within a specified territory or area.

This characteristic of "community" as a physical or geographic entity informed the work of Rothman (1974) an often-quoted writer in the area of community organization. He built his definition of "locality development" on the notion of community as a geographic or spatial entity. McKnight (1994) too, characterizes "community" spatially. When asked "what is community? in a recent CBC radio interview, McKnight rather flippantly replied "in your mind". Ordinarily, he describes community as the "space where citizens prevail" (CBC, 1994, p.2). McKnight advocates that citizens "reinvent community", by viewing communities in terms of their positives, rather than negatives, and critically analyzing the "professionalization" of people, problems and communities. His argument is that contemporary communities are deficiency-focussed, and that a resource or capacity-focus re-orients the way that we think about people and their communities. He blames much of this orientation on the professionalization focus within North American society. As an example, he points to the development of palliative care. No longer do neighbours comfort each other in times of death. Rather, according to McKnight (1989; 1994), grief has become pathologized, with counselling available from professional grief counsellors, or palliative specialists. Hence, McKnight's idea of the "reinvention of community" as a process beginning with how we think about where and how we live.

Feminists (Adamson, Briskin and MacPhail, 1988; Dominelli, 1990) have questioned the orthodoxy of traditional views of community, arguing that trying to form one global definition of community has revealed that there are many kinds of communities, and that there are often more differences than commonalities between people in traditional communities. "Communities" which are geographically defined may include people with affiliations to different political, sociological, economic,

religious, racial, ability, and gender terrains or groupings.

Feminists have thus contributed to the development of a more differentiated vision of "community", adding an analysis of privilege, oppression, prejudice, power and control. Hence, the "Black community", the "women's movement", "women living in poverty", "people living with AIDS", "the elderly", to name but a few (Dominelli, 1990). Such communities of people define themselves in terms of their struggles and concerns, analyzing their position relative to others in terms of power and control.

As I became more familiar with the "New Directions" literature, I saw that "community" was used in a traditional sense as regards regionalization; as a geographic entity, encompassing the persons who live within specified boundaries. In the "New Directions" documents there are "groups" (aboriginal, women, children) identified by their problematic access to services (p. 13). However, it seems that these "groups" with particular needs must somehow have their needs met through membership in traditionally defined communities.

I find this idea puzzling, that these "groups" identified as having particularly problematic access to services must have their needs met through their geographic community affiliation. As I noted in the Feminist literature, it is difficult to identify the diversity in communities, in terms of income, gender, ethnicity, and status, when sweeping rules of geography become the main category of inclusion or exclusion.

The important issue of "community" composition, and the power relations therein is overlooked in the "New Directions" literature. Regions are pre-defined according to existing regional health districts. Ultimately, the Ministry of Health retains the decision-making authority of how each region and community will be defined. Yet, it is these "communities" which will participate in the "New Directions" process.

## Community development

The "New Directions" literature uses the term "community development" (Ministry of Health and

Ministry Responsible for Seniors, 1993, p. x) as a way of building community and public participation in the regionalization effort. While not clearly defined it appears to correspond with what Rothman and Tropman (1974) call "locality development". There seems to be a taken-for-granted notion that community development is a good thing and will result in both public participation and new "partnerships", within a regionalized planning and decision-making process.

Rothman and Tropman (1987) identified community or locality development as community change through broad participation by citizens in goal setting and action, at the local level of community. Community initiative and democratic process are important aspects of locality development, according to Rothman and Tropman.

Labonte (1993), a Canadian community development author, discusses community-based and community development programming. He differentiates the two concepts according to control, stating that the community has greater ownership and control in what Labonte terms "community development programming". As well, the approach to planning is different in community-based and community development programming. In the former, there are usually defined program time-lines, and specific ideas about outcomes, and their measurability. In the latter, the work is often longer term, without defined time-limits, and the desired outcome is an increase in the group's capacity to effectively act in the social world.

The work of Rothman & Tropman and Labonte is helpful in gaining an understanding of the way community development is conceptualized in much of the governmental health promotion and community development literature. Rothman and Tropman's notion of "locality development" and Labonte's idea of "community development programming" have commonalities. Both emphasize broad community participation in the planning process, and presuppose that the broad community is involved in defining both the process and the outcome of the process.

Dominelli (1990), a feminist, challenges the notion of traditional community or locality development as able to "give voice" to people. She criticizes much community development practice as "primarily concerned with industrializing non-capitalist areas of the globe and bringing them under

capitalist hegemony" (Dominelli, 1990, p. 5). Dominelli notes that modern society, based on capitalism, operates on a concept of scarcity of resources, where redistribution only occurs at the expense of others. Liberal solutions to meeting needs do not challenge the "system" itself. According to Dominelli, there is real danger in community work which only superficially examines society's distribution of power and resources. Such an approach often ends up suggesting that increased "participation" in decision-making is a sufficient answer. Rather, Dominelli argues (similar to McKnight, 1994) this approach leads to the pathologizing of individuals and communities.

Dixon (1989), an Australian community development author, describes the various conceptualizations of community development and discusses the limits and potential of community development in terms of change. She notes that while community development in health promotion is often characterized as being capable of producing fundamental social change, in practice, community development is limited to influencing personal, or planned change. As an example, she cites as an example community development projects intended to lead to redistribution of resources, such as land, noting that the changes which actually resulted (such as increased feelings of belonging to a group) tended to be of a personal and individual nature. Dixon relates this point to the origin of the process, arguing that "the sponsorship of community development is the key to its potential in personal and planned social change" (Dixon, 1989, p. 83). She describes how governments have tended to introduce "community development" when problems arise, imposing it from outside, for the "good of those inside" - a paternalistic sort of intervention (1989, p. 88). Dixon challenges the idea of community development as partnership-building, stating that the process of community development "accepts and does not challenge the local power relations" (p. 88).

Included in Dominelli and Dixon's analysis of community development are the crucial notions of power and control, process sponsorship, gender, patriarchy, and capitalism. Both authors are critical of community development when it approximates locality development as described by Rothman and Labonte. Dominelli and Dixon remain sceptical of government-initiated community development processes as being capable of more than planned social change or improved service coordination

(Dominelli, 1990; Dixon, 1989). The sponsorship or origin of the process determines outcome, they assert, as the control or power tends to remain with the sponsoring body, rather than with the "community".

The "New Directions" literature uses the term "community development" as a strategy for building community and public participation in health planning. The notion seems to roughly correspond with Rothman & Tropman's vision of "locality development". This raises a number of questions in relation to this study. Rothman & Tropman's work indicates that locality development is an open-ended process of community determination. Yet, "New Directions" sets out a number of pre-defined outcomes of community development, including regional health boards and community health councils.

Government sponsorship of this health reform process also brings to light Dixon and Dominelli's concern regarding control. If, as they argue, government sponsored community development is rarely successful when control of the process remains with the sponsor, there are serious implications for the "New Directions" process. Called into question is the actual ability of government-sponsored community development to build the "participation" and "partnerships" outlined in "New Directions".

## Participation

In the "New Directions" health reform process community development is conceptualized as a strategy for developing broad participation and new "partnerships" with citizens in planning and decision-making about health care. Like community development, "participation" and "partnerships" are taken-for-granted concepts, assumed to be beneficial. While both terms might be assumed to include the sharing of health planning and decision-making responsibilities, the literature reveals that the concepts of "partnership" and public "participation" require attention to the issues of power and control.

Participation is defined in the literature as "the process by which ordinary people can have some say in prioritizing, planning, delivering and reviewing services" (Community Participation Group, 1991). McKnight (1989; 1994) stresses the "citizen" nature of participation, re-orienting the thinking, so that the people involved are not patients, or clients, or consumers. Rather, they are citizens, full members of their

communities, exercising their democratic right of involvement. Charles and DeMaio (1993) raise the issue of the nature of participation by individuals. Individuals, they state, can participate in decision-making as users of service, or as public policy-makers. As participants, they can consider issues at the individual treatment level, the regional service level, or the policy level. However, Charles and DeMaio (1993) raise an interesting issue. Despite the popularity of participation, there is little research evidence to show that lay participation results in locally or regionally-responsive decision-making.

Hume (1993) notes that citizen participation is an essential characteristic of community development, and that different "degrees" of participation are possible. Arnstein (quoted in Hume, 1993) utilized a "ladder" ideation of participation - with manipulation at the lowest rung, and full managerial control at the highest. Brager and Specht (quoted in Community Participation Group, 1991) describe the control given the community, ranging from low to high participant involvement and action. "No control" illustrates the least ownership, whereas "control" indicates the highest participation. Pateman, (in Hume, 1993) describes participation as "pseudo, partial, or full", depending on the inherent power relationships. "Pseudo" corresponds to consultative type participation, where there is little real control of the process. "Partial" (like Labonte's notion of community-based programming) gives some control to the community. Full participation grants total control of the process and outcome to the community (Hume, 1993).

O'Neill (1992) writes about "actual participation", describing the "natural experiment" of community participation in Quebec. He concluded that community participation and community empowerment are two different things. In Quebec, O'Neill saw the consolidation of the power of professionals and bureaucrats, rather than the community. O'Neill argues that what is needed is a framework to understand the dynamics of power relationships in post-industrial societies, and suggests that a feminist approach to "power" would require a rethinking of participation and empowerment.

Through the literature, it is apparent that there are many different ways to participate and that participation has had many different effects attributed to it, including better planning and decision-making. O'Neill draws our attention to the notion of "power" and how this affects the control that individuals and communities have in participatory processes. Like Dixon and Dominelli, (regarding

community development) O'Neill raises the question of whether public participation will succeed, given current power arrangements.

## Partnership

In the "New Directions" documents, the term "partnership" is introduced, with the public, health providers, government, regions, and communities all becoming "partners" in the process. As with participation, partnership introduces the notion of power, as the concept partner constitutes an entity with some amount of power vis-a-vis other partners.

Partnership is described as a "willingness to work with another to reach an agreed upon goal" (Department of National Health and Welfare, 1993, p. 14). In the literature, partnerships have potential strengths and weaknesses. Claimed strengths include improved care due to the linkages forged, increased cost-effectiveness and improved health (Department of National Health and Welfare, 1993). Weaknesses include the difficulties of integrating a fragmented system through partnerships, and of negotiating the different organizational and sectoral roles and values.

Boudreau (1991) is critical of the notion of "partnership", based upon an examination of partnership as a new strategy in Quebec's mental health policy arena. Boudreau notes that the term partnership instills hopes and expectations through the language of fairness and equity. She argues that partnership is an improvisation which "attempt[s] to create at the regional managerial level, a democratic resolution to the highly objectionable and conflict-producing coexistence of competitive corporatism for professional corporations and public sector unions, and unbalanced pluralism for the weak" (1991, p. 325). Boudreau makes the point that this notion that stakeholders are partners is occurring in a system where neither the rules of the game, nor the structures are altered. Rather, the structural constraints to "true partnership" remain embedded in the restrictive Canadian health care system. True partnership, Boudreau concludes, requires deeper structural changes.

This highlights the issue of "offloading", in relations to "New Directions". Those involved worry that regionalization will result in "offloading" of responsibility for health care decision-making and

planning without sufficient resources to carry out the necessary changes (Joyce, 1994). The concept of partnership seems to be "good". Yet, as Boudreau has demonstrated, what is purported to be "partnership" may not result in equity if the pre-existing power arrangements are not (or can not be) changed to ensure that the partners share "power".

The "New Directions" documents describe all of the stakeholders as "partners" - the public, communities, providers, and government, through "participation". Given the preceding discussion, in my research I will explore whether the "rules" or structures have been changed. To actually be a partner (and not just a pseudo-partner), one assumes that in some way the government's control of power will have to change. In order to understand this more clearly, I next examine the concept of power.

## Power

"New Directions" speaks of "empowering" communities, providing regions and communities with the ability and authority to make locally appropriate plans and decisions. The various terms connected with the idea of "power" - power, powerlessness, empowerment, and control - have emerged as concepts linked with the preceding discussions on community development, partnership and participation. While "power" and its presence or absence often enters the literature on these topics, it tends to be in ill-defined or abstract terms. Just what is "power", and how is it related to "New Directions"?

Power is associated with control, as something that an individual, group or community completely possess, possess to some degree, or lack entirely. Lord and Farlow (1990) link powerlessness and empowerment with the absence and presence respectively, of personal control. It benefits those who have it, and is a barrier for those who do not. "Powerlessness" is characterized as a lack of control over destiny, while "empowerment" has been described as a process whereby those with less power gain some amount of individual or community decision-making control or of resources through participation (Wallerstein, 1992, 1993).

"Power" is frequently treated as a finite entity, in that if it is shared, there is a loser and a beneficiary. Feminists, however, depict the concept of power differently. Briskin (1990) argues that

patriarchal forms of power are "over" others, while Adamson, Briskin, and MacPhail (1988) point out that people in our society have different amounts of privilege and power, based on a number of characteristics - gender, class, race, and sexual orientation, to name but a few. Those with "power" frequently have a vested interest in keeping it, and resist redistributive efforts. Power, according to Adamson, Briskin, and MacPhail (1988) and Latour (1986), is embedded in "power relations", which are exercised through modern institutions.

Smith (1990) states that power, when seen as a concept, is mystifying, capturing a sense of "something", yet incapable of explicating this "something". She challenges the notion that power somehow "happens", in the absence of human endeavors. Rather, Smith argues that power arises in, and through, people's actual activities. Her materialist analysis raises power from a nebulous concept to something that can be studied, through examining the activities of people. Power, Smith argues, arises as "people's actual activities are coordinated to give the multiplied effects of cooperation" (1990, p.70). She introduces the notion of social relations - "the definite modes in which people's activities have come to be organized", which "are daily and nightly both reproduced and changed as people's local activities articulate to, coordinate with, and are determined by them" (1990, p. 202). Social relations are the courses of social action which involve more than one individual and whose "participants are not necessarily present or known to one another" (1990, p.155). Hence, "power" is socially constructed. Smith argues that there is power in objective forms of knowledge, facts, and texts; "power" which arises through the socially organized practices which are used to accomplish these very things (Smith, 1987, 1990; Campbell, 1988).

"Power", as described by Smith, is intimately connected with what she calls "ruling relations"; the objectified, impersonal complex of practices which are organized, and which organize our lives. She states that the "relations of ruling" is "a concept that grasps power, organization, direction, and regulation as more pervasively structured than can be expressed in traditional concepts provided by the discourses of power", arguing that ruling in contemporary society is linked with patriarchal forms of experience (1987, p. 3). What Smith is getting at is that ruling involves more than the "state", government, or management.

Yet, it includes all of these, as well as the professions, law, business, financial management, education, and all of the activities involved in training those that will "govern".

"Ruling", then, has a particular character, as the "local and particular actualities" of people's lives are changed into "abstracted and generalized forms" - the extralocal (1987, p. 3). This is accomplished by textually-mediated or documentary processes, through which the locally experienced is transformed into abstract form. Through organized practices such as textually-mediated ruling processes (for example, program eligibility criteria), the "extra-local" rules and procedures organize local experience and determine how it can be "known", responded to, etcetera. This is ruling - practiced through administration of experience. Smith insists that the discovery of relations of ruling begins with people - women and men, living their everyday lives.

It is evident that the Ministry of Health has conceptualized "New Directions" with the notion of decision-making authority or power as an entity that can change hands, moving from the centre (and the previous arenas of planning and decision-making) to the regions (1993, p.x). In my study, I will follow Smith's conception of power as enacted through actual practices. Smith's analysis of "power" as a part of the "relations of ruling" makes it clear that it is necessary to move beyond talking about power, to an examination of the "relations of ruling" and their connection with the processes of management, bureaucracy, and policy implementation. In order to study the "relations of ruling" as "New Directions" is implemented, it will be necessary to examine the actual activities of people, the social relations which involve them, and with which they are involved on a daily basis.

## Management, Bureaucracy, Implementation and Ruling

"New Directions" is a public policy to be implemented in the province of British Columbia through regional health boards. This process is intended to result in a "decentralized partnership approach to health management" (1993, p. x) such that responsibility for management of services currently delivered by the Ministry of Health will be devolved to the regions. Both the notions of decentralization and public participation have been described as new management approaches

(Department of National Health and Welfare, 1993). I intend to examine some of the concepts used in policy documents, specifically those related to implementation. It appears that "management", "administration", and sometimes even "policy implementation" are used interchangeably.

Public policy, according to Pal (1992, p. 2) is a "course of action (or inaction), chosen by public authorities to address a given problem or interrelated set of problems" - hypothetical solutions to perceived problems. Pal states that the public policy process is a political process, resting on power, influence, interests, and words - "political fights are conducted with money, rules, and with votes, to be sure, but they are conducted above all with words" (D. Stone, quoted in Pal, 1992, p. 15). Boudreau (1991) also sees words as powerful, describing policy-making as the search for politically powerful words; words which themselves come to be seen as "truths".

O'Toole (1986), states that "implementation" involves putting policy into action or practice. Much of the literature and research about implementation tends to use the word "implementation" as a given, presenting characteristics of implementation such as "real world" constraints (Pal, 1992), top-down versus bottom-up approaches (Sabatier, 1986) and programmed or adaptive strategies (Berman, 1980). In this body of policy and implementation literature, these concepts remain abstract, words and ideas only. Missing is an analysis of policy as created by people (i.e. members of the provincial government), and of implementation as something that people (i.e. public administrators) "do".

In this study, I am seeking a way to conceptualize policy and its implementation as researchable practice. Hence, my study requires a conceptual framework in which people are seen as active and implementation is more than conceptual. As a result, I look to a different body of literature.

Ferguson (1984) provides a critical analysis of the taken-for-granted workings of bureaucracy, management and administration. She describes "bureaucracy" as both a structure and a process; a structure in that it is a "fairly stable arrangement of roles and assignment of tasks"; and a process in that there is a "temporal ordering of human action that evolves out of certain historical conditions toward certain political ends" (Ferguson, 1984, p. 6).

Ferguson views modern bureaucracy as a type of social system which supports and maintains

capitalist enterprise. Bureaucracy, according to Ferguson, "maintains social control", and is staffed by "functionaries who can claim expertise in relevant areas" (p. 9) through a variety of ways such as the elimination of uncertainty, the "appeal" to efficiency, the formation of a peculiar, semi-secret language, the diffusion of responsibility and decision-making, and the silencing of "victims" through the claim of ideological neutrality. Ferguson advocates a feminist discourse to "provide a way of thinking and acting that is neither an extension of bureaucratic forms nor a mirror image of them, but rather a genuinely radical voice in opposition" (1984, p. 29).

Cassin (1993), like Ferguson, is critical of bureaucracy. However, her work allows us to understand human agency in the reproduction of bureaucracy as she describes "management" as not only "a method of thinking" (1994, p. 7) but also as a set of practices located in "organizational contexts and executed by authorized individuals". She also notes that management is taught as an academic discipline which is involved with training, research and theory development, and hence is "transorganizational" in that its concepts are then applied across organizations. Cassin introduces the concept of management as "technology", describing the methods of "managing production, people, finance, and markets, which have been systematized through concepts, theories, protocols" to instruct the formation of "policies, rules, and principles" in organizations. Franklin, too, uses the term "management technologies" as both the organization of work and people and as a system (1990). Her analysis (like Smith's) is useful as it accounts for "agency", allowing us to see that "management technology" is the organized work of people.

Smith (1987, 1990) argues that "management" and "bureaucracy" are aspects of the "relations of ruling", in those institutions which "organize and regulate society" (p.3). Policy issues are socially constructed, formulated as a result of administrative relevance, not individual or personal significance. Government, in this view, formulates policy issues in congruence with administrative requirements, not with their personal significance to individuals in mind. Campbell (1988) concurs, arguing that management priorities in a public sector organization "express the interests of the state" (p.43) and that may mean displacing professionally-organized concerns of practitioners or needs of clients.

"New Directions" is ostensibly about shifting decision-making and planning authority or power

from the Ministry of Health to the regions. However, there are some unsettling contradictions within these ideas. If Smith is right, contemporary bureaucracy is organized to operationalize or implement policies which serve to "rule" and organize. Large organizations, such as the Ministry of Health, participate in "ruling" through the construction of a web of structures and practices, and a complex of social relations which are extralocally organized.

Yet, in "New Directions", regionalization is conceptualized as occurring through public participation and the development of new partnerships, with community development as a potential strategy. To accomplish this, it seems that the Ministry's "rules of the game" would need to be changed. Central to my research is this emerging contradiction - of the "bureaucracy" which has traditionally "ruled" now changing its practices so as to "empower" those who seek to operationalize "New Directions" through community development, participation, and partnerships.

Smith proposes a method of feminist research which emphasizes the discovery of "how things work, how our world is put together, how things happen to us as they do" (1987, p. 34). This method, based in a social construction of knowledge methodology, is institutional ethnography, beginning with an actual situation as the "point of entry", in order to explore the social relations organizing it. That is where I begin, with people's actual activities as they undertake to implement "New Directions". I start from the perspective of those people who are actively, ongoingly enacting "New Directions" on a daily basis, as staff or volunteers of the Regional Health Board. My aim will be, as Smith says, to explicate the extralocal coordinating processes organizing the local.

My questions then become, **"Through what opportunities (activities, decisions) can/does the Regional Board establish regional priorities, objectives, and plans in order to develop a regionally-defined character for health care?". "How does this policy get put into practice through everyday activities of real people?"**

# CHAPTER TWO

## RESEARCH METHODOLOGY

*"We begin from where we are. The ethnographic process of inquiry is one of exploring further into those social, political, and economic processes that organize and determine the actual bases of experience of those whose side we have taken." (Smith, 1987, p. 177)*

I have selected institutional ethnography as the research methodology for this study, based upon institutional ethnography's potential to explicate "how things work". Institutional ethnography is an interpretive methodology based within the non-positivist paradigm, and relying on a social organization of knowledge analysis. The non-positivist paradigm is built upon the premise that reality has no existence outside of that which is constructed or created as it is lived. As Smith, (1987, p. 125) states "our world is continually being brought into being as it is and as it is becoming, in the daily practices of actual individuals". Non-positivism stands in opposition to the dominant positivist worldview, which rests upon the premise that an objective "reality" exists, in and of itself, and hence can be observed, preferably from an objective, value-neutral position (Jackson, 1984). Thus, the approach to research from this paradigm is inherently different from traditional positivist research.

Traditional positivist research starts with theory and concepts, utilizing them to observe and describe the world. Research questions are developed and tested, using qualitative or quantitative strategies. Human research involves people as research "subjects", studying the people themselves, their attitudes, perceptions and actions. Statistical sampling, then, properly constituted and built on the concept of "representativeness" allows for the application of the research conclusions to the general population (Smith, 1987). Objectivity (and the validity it confers within the positivist paradigm) is built upon the idea that it is not only possible, but preferable to stand outside the phenomena being studied, in order to gain neutrality (Smith, 1987).

Institutional ethnography seeks to explicate "how things work". As Smith, (1987, p. 160) states, the "movement of research is from a woman's account of her everyday experience to exploring from that perspective the generalizing and generalized relations in which each individual's everyday world is

embedded".

As I noted earlier, institutional ethnography arises out of an understanding of knowledge as socially organized. Campbell (1996) notes that a social organization of knowledge conceptual framework involves "grounding assumptions". One such grounding assumption is that of multiple perspectives or versions of reality. Hence, the researcher does not aim to establish a single "truth". Another grounding assumption is that "organizational knowledge is text-mediated in contemporary organizations in Canada" (Campbell, 1996, p. 6) and that the work which the researcher observes and hears about is coordinated by text-based practices. Campbell adds that the researcher is "being attentive in [her] fieldwork to how the written word organizes what gets known and authorizes that version of it" (1996, p. 7). This was important for my study, as I came to understand how public administration works as a ruling practice.

Institutional ethnography allows us to explore "those social, political, and economic processes that organize and determine the actual bases of experience of those whose side we have taken" (Smith, 1987, p. 177). In other words, this method provides a way of "investigating empirically how ruling works" (G. Smith, 1990, p. 637) beginning from a particular point of entry. Campbell (1996) notes that this form of analysis can enhance understanding and open up possibilities for all of us whose lives are subject to ruling relations.

In institutional ethnography, the researcher "begins in experience and returns to it, having explicated how it happened in the way that it did" (Campbell, 1996, p. 3). In other words, through institutional ethnography it is possible to explore how experience is socially organized. This requires "reflexivity" (G. Smith, 1990) recognizing that the researcher, too, is inextricably linked, as an insider, to the actuality of her everyday world, the same world inhabited by those whose experiences the researcher is exploring. Reflexivity is an inherent and necessary aspect of a social construction of knowledge approach; inherent as the knower and known are not separable entities, and necessary in order for the researcher to understand the social relations within which "reality" is produced (Garfinkel, 1967). As a non-positivist researcher, I start from the view that reality only exists as it is being co-created in the activities of people (Smith, 1987). Hence, from this perspective, the very notion of "objectivity" is called into question, as it is

impossible to "stand outside" of the reality which one is ongoingly creating. As Smith (1987, p. 142) notes, "her (the researcher's) own seeing arises in a context structured by the same system of social relations structuring the everyday worlds of those whose experience provides the problematic of her inquiry". In my inquiry, this meant that I listened and responded in a way that showed my understanding, making sense of what I was seeing and hearing as I went along, pursuing relevancies as my understanding grew - a "reflexive" construction.

Where research within the positivist paradigm speaks of "validity", Smith (1987) speaks of "ontological faithfulness", "faithfulness" to the presence of the subjects, to the world co-created, and to the explication of the actual everyday practices both local, and extralocal. In institutional ethnography, no attempt is made to "sample" the population in order to generalize (Smith, 1987). Rather, the emphasis is on explicating how the phenomena being studied "works" or "happens" (Smith, 1987), in explicating what Smith (1987) calls "generalizing" social relations. She notes that people's daily living is embedded in "invisible" social relations which generalize and are generalized. This is distinctly different from "generalizing" as used within the positivist paradigm. As Diamond (1992) writes, institutional ethnography allows the researcher to explicate those everyday actual social relations, which are general, and which generalize, in order to understand "how things work".

## Data Collection

When I undertook this research, I thought that I would be developing an understanding of the Regional Health Board's attempt to implement "New Directions". Within a few months, I recognized that a related and intertwined process was in progress in the region of my study. The Regional Health Board, in addition to their "New Directions" work, had taken on a set of negotiations intended to result in the transfer of mental health services and programs to the region. My attention was drawn to the transfer negotiations, as I began to understand that this process would allow me to see and understand the social organization of this attempt by the Regional Health Board to plan for and negotiate community priorities. By seeking the experiences of the members and staff of the Regional Health Board who were attempting,

through community development and public participation, to understand and negotiate for the community, I found my "point of entry" to an exploration of the social organization of the implementation of "New Directions" in a region of British Columbia.

I gathered the data for this study over approximately an eighteen month time frame between March, 1994 and December, 1995. That is not to say that I was actively engaged in the process of gathering data during this entire time. Rather, I gathered data on a part-time basis as events unfolded. During the time period of my study, the members and staff of the Regional Health Board were involved with the development of the Board's governance framework, negotiations with the Ministry of Health for the transfer of mental health services and programs to the region were ongoing, and community health councils were forming and beginning to give consideration to community interests and priorities.

I gathered and used data from a number of sources, including interviews, observation and texts or documents. I interviewed staff and trustees of the Regional Health Board in order to understand their experiences of attempting to involve the community on a day-to-day basis, in community planning and priority-setting. The people that I chose to interview were those who were **enacting** the implementation that I wanted to explore. Campbell (1996) explains how when speakers speak from experience, the social relations of that experience is brought into the researcher's presence. As I began to see that the practices of public administration within the Ministry of Health socially organized the experiences of Regional Health Board members and staff, I realized that I needed to gather data which would help me to understand the work of Ministry officials. This realization reflects and realizes my theoretical understanding of how the world is organized. Hence, I also interviewed a number of senior Ministry of Health officials involved in "New Directions" implementation to try to understand how their work is organized.

I started my data gathering through observation of the ongoing activities of staff and trustees of the Regional Health Board. I attended staff meetings, Board meetings, community health council meetings and day-long community workshops. Initially, I felt overwhelmed, as the history of the Regional Health Board and the local expression of "New Directions" was extensive and at times, convoluted. I

persevered over many months, observing a broad variety of Regional Health Board activities. I kept field notes of my observations, trying to capture the activities, the quotes, and my own reflective experience with the Capital Health Board. Campbell (1996) writes "[o]bservations of everyday life, where the researcher captures the language used by the participants, can, like interviews, also be used to gain entry into the social organization" (p. 9).

As I gained an understanding of the work of the Regional Health Board, my analytic attention was drawn to the process of negotiations between the Board and the Ministry of Health, regarding transfer of authority for regional mental health services and programs. During nearly every Board staff meeting, there would be discussions as to the state of these negotiations. After many months of such observations, I began to understand that the Board was coalescing their "New Directions" work with their attempt to transfer authority for mental health services and programs to the region. I decided to delve further into this story, interviewing people involved with the mental health transfer negotiations to try to understand their experiences of "hands-on" community development. Later, I explored texts that circulated in regards to this mental health negotiation (both Regional Health Board and Ministry of Health documents) in order to provide a further depth to my analysis. In the data chapters, these texts are ifentified by name.

In addition to the ones I quote, I examined myriad documents, including minutes of staff, Regional Health Board and community health council meetings, documentation of the large community development forums, and materials (i.e. letters) exchanged between the Regional Health Board and the Ministry of Health. I sought out specific Ministry of Health publications, in order to help me to understand the organization of the Ministry of Health, and to see how they documented aspects of the mental health transfer negotiations. Throughout my textual analysis, I remained attentive to "how the written word organizes what gets known and authorizes that version of it" (Campbell, 1996, p. 7). My understanding of this point grew as I began to grasp that the Board trustee and staff experiences of frustration regarding the mental health transfer process developed as they attempted to ensure the inclusion of local relevancies into the negotiations. Later, when the Ministry of Health developed its own textual version of the negotiations, it became apparent that relevancies *other than* the community-held

priorities were embedded in the Ministry version of events.

During this research, my own experience, observation and interpretation of events became crucial to understanding and developing the analysis which follows in later chapters. Beginning with the experiences of those Regional Health Board trustees and staff involved in the mental health transfer negotiations and using these experiences as "instances" of implementation, I began to look at how public administration influenced what happened.

This thesis is not an evaluation of the "New Directions" policy, or of the implementation work of the Regional Health Board and the Ministry of Health. As a researcher, I do draw conclusions about the activities through which this policy is implemented. My conclusions, however, do not focus on the adequacy of the Board's version of community development as an implementation strategy. Rather, these conclusions are about policy being implemented through the particular community development strategies that I observed being used.

# CHAPTER THREE

## OVERVIEW OF THE MENTAL HEALTH TRANSFER

In this chapter, I provide the story of the Regional Health Board's attempt to negotiate the transfer of mental health services from the Ministry of Health to the region, from the point of view of Board staff and trustees. I begin by outlining the development of the Regional Health Board. Later, I describe the context of changes within the mental health system in British Columbia. Finally, I show how the Regional Health Board went about its "New Directions" and mental health reform process utilizing community development, with its central notion of participation, as its choice of methodology. The data utilized in this section include interviews with staff and trustees of the Regional Health Board, as well as both Ministry of Health and Regional Health Board documents.

### The Development of the Regional Health Board

The documents outlining "New Directions" describe the development of regional health boards and community health councils as central to regionalization and set out citizen participation as a strategy necessary to achieving health care system reform. As is stated in "New Directions",

> "[g]reater public involvement in the health system will ensure that health needs and services are more closely matched. Increased participation is an essential part of a responsive and flexible health system" (Ministry of Health, "New Directions", 1993, p. 13).

In the region where this study was undertaken, there was an earlier regional planning initiative which pre-dated the "New Directions" process. This earlier regional planning body (known as the Regional Health Council) formed the interim Regional Health Board[3], appointed by the Minister of Health in March of 1992 (Regional Health Board briefing notes, 1994). Early work of the interim Regional Health Board included the development of the Board and initiation of a local mental health consultation (Interview with Regional Health Board staff member, December, 1994).

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3 Hereafter called the 'Board', the Health Board, or the Regional Health Board.

The interim Board became an officially designated Regional Health Board in September of 1994, under legislation included in the newly acclaimed Bill 45 (the Health Authorities Act). Designation, under this Act, was seen as the first step in decentralizing health care and transferring authority from the Ministry to the regional and community level (Ministry of Health, "New Directions", 1993). According to "New Directions" documents, designated regional health boards would gain responsibility for providing some health services on a regional basis, including responsibility for the funding of regional and sub-regional health service delivery, while community health councils, in turn, would become responsible for the coordination and integration of health services on a local basis, including the operation of hospitals and other facilities in the community (Ministry of Health, 1993).

## Regional Mental Health Planning and Services

Besides having to develop the Regional Health Board, another task within the region was to transfer mental health services. In 1985, long before the Ministry's "New Directions" policy was born, British Columbia citizens were involved in a province-wide mental health consultation process (Ministry of Health, 1987). Many issues and concerns were raised about the mental health system, both by those who used the system and those who worked within it (Tedlie Clark Management Group, 1992). Of concern were issues such as the deinstitutionalization of mentally ill persons (partly as a result of the advent of psychotropic drugs), the looming closure of a number of large psychiatric facilities, and the generally-held perception that "community services have not developed to take the place of the hospital" (Tedlie Clark Management Group, 1992, p. 19). People wanted to have a voice in the mental health system, both in terms of their own care, and in the planning of the system.

Local problems and concerns continued to emerge and plague the Ministry of Health's Mental Health division, the area responsible for planning, organizing, managing and evaluating most mental health programs and services. In February, 1992, a further mental health consultation process was initiated in the region of my study, with funding provided through the Mental Health Services division of the Ministry of Health.

"At the Minister's specific request, the Regional Health Council will give its immediate attention, through Coalitions of Health [a type of task force] to three key issues on a priority basis: seniors, mental health, and children and youth" (Briefing notes, Regional Health Council, April 22, 1992, p. 2).

This process became known as the "mental health coalition project" and was undertaken by the Regional Health Council, which would later form the interim Board. There was a sense of urgency, that this process had to begin sooner, rather than later. As the mental health coalition consultant's report noted,

"[t]he urgency of some of the issues regarding mental health, and the extensive consultation time required prior to the establishment of a Mental Health Coalition dictated that this process commence prior to the formal establishment of the [Regional Health Board]" (Tedlie Clark Management Group, "Mental Health Coalition Working Document", 1992).

Once the interim Board was established, however, the mental health coalition project reported to them (Interim Regional Health [Board] minutes, March, 1992).

The "mental health coalition project" consisted of a series of community information and planning sessions, to facilitate public consultation (Interim Regional Health [Board] minutes, July 17, 1993). The interim Board submitted their report on mental health in the region to the Minister of Health in the Fall of 1992 (Interim Regional Health Council Minutes, November, 1992). At issue in this process of consultation was the prevailing view that mental health services in this region were in disarray. The consultant's report put it this way:

"In recent years, a number of problems have been identified in the regional mental health system of care. Within the current system, no mechanism exists for determining mental health goals and priorities for the entire community..." (Tedlie Clark Management Group, 1992, p.v).

Out of this consultation arose a number of ideas for improving and integrating mental health services within the region. A central theme was the need for ongoing citizen participation and local control in the organization, development and operation of mental health programs. The consultants noted:

"There was consensus on the need for adequate and regular community input to the planning, funding and delivery of mental health services.... Many individuals and groups stressed that it was important to let the

community become part of the solution" (Tedlie Clark Management Group, 1992, p.vii).

This recommendation, however, was not unproblematic. Organizing for "regular and adequate community input" would require planning so that people had real opportunities for participation.

In November of 1992, the then Minister of Health, Elizabeth Cull, responded to the region's report, indicating to the Interim Regional Health Board that she was interested in transferring responsibility for mental health services from the provincial Ministry of Health to the community within the context of regionalization. She indicated that the interim Board should begin negotiations with the Ministry of Health, once they felt sufficiently prepared for the transfer of mental health services and programs (Regional Health Board briefing notes, 1994).

The Board gave careful consideration to Cull's interest in transferring mental health services and programs, and appointed a Mental Health Task Force to "develop a plan for the [Board's] assumption of responsibility for mental health services" (Regional Health Board, "Final report of the mental health task force", June, 1993, p.v). The members of the Task Force made a decision to build on the earlier consultation process in the region.

"For several months preceding the formation of the task force, community members, consumers and care providers had been engaged in a variety of community consultations about mental health services in the region. The task force built on the results of the consultations to develop a vision for mental health service delivery and to identify strengths and weaknesses in the current system" (Regional Health Board, "Final Report of the Mental Health Task Force, June ll, 1993, p. 2).

The Task Force, chaired by a Board trustee, developed its membership according to a representative model, based on "who needs to be involved" (Interview with a former Regional Health Board staff member, May, 1996). The intent was for the Mental Health Task Force to be community-based, drawing its members from ordinary citizens whose lives were affected by mental health issues, such as so-called mental health "consumers" and their family members, and from people who were employed in providing mental health services. As one Board trustee described it,

"the mental health task force involved people who had been trying to use the service, their families, advocates, and people who worked in the system" (Interview with a Regional Health Board trustee, June,

1995).

The Task Force continued its work in ways which encouraged participation by people who were involved with, or interested in mental health services and programs. And people continued to have plenty to say about the region's mental health services. Not just mental health clients and their families, but the people who worked in the system, all had complaints and concerns. People indicated that they experienced difficulties identifying and accessing the mental health services and programs that they needed, and that their needs were broader than current mental health treatments offered. As a Regional Health Board trustee observed,

"They (clients or consumers) had a problem entering the system, frustration with "gatekeeping". Having entered, the services related to their needs might not be available. There are so many players in the uh, field, that it was difficult for an individual to find out what was available or appropriate. The problems, quite apart from the medical aspect are related to other health factors such as affordable housing, jobs, job training, financial security and underlying all this, the lack of acceptance by the general community of uh, just what was involved with mental health and illness, misconceptions, etcetera" (Interview with a Board trustee, June, 1995).

The Mental Health Task Force also discovered that besides individuals' problems of access, there were organizational difficulties within the system of mental health services. As people who were involved with the mental health system described their experiences and named the problems that they found, serious inequities both for agencies and their workers became evident.

"The fundamental problem was that the mental health community came to the realization that the whole system was not adequate to meet people's needs. Particularly this was evident among community providers, who were not adequately funded, and who had little assistance from the Ministry of Health" (Interview with a Regional Health Board trustee, June, 1995).

This Board member was referring to the perceived inequities in funding between different organizations providing mental health services. Some organizations, such as hospitals, receive all of their funding from the Ministry of Health while others, such as small community agencies, might receive only a portion of their funding from the Ministry. The latter organizations frequently would find themselves in a position of having to secure funding from a variety of sources. The following informant agreed, adding,

"[t]here are large wage inequities between ministry, community and hospital employees. Also, different expectations had emerged. The Ministry has scrutinized their contracts through agencies more than their own services" (Interview with a Board staff member, December, 1994).

This informant was referring to the Ministry's various methods of delivering Mental Health services and its different accountability practices. Agencies which "contracted with" the Ministry to supply services were subject to more detailed and thus, time-consuming reporting. One such complaint was about the Ministry of Health's practice of linking the future budgets of contracted agencies to specific outcome-oriented data. This practice was costly to agencies in various ways. It meant an annual scrutiny of many aspects of their work, with intense effort going into documentary justification and resulted in a sense of insecurity, and having to scramble during budget renewal. Managers of contracted agencies argued that the Ministry's own direct service operations were not subjected to the same degree of scrutiny.

The Mental Health Task Force worked with its participants to develop a report, which they released in June of 1993. To begin to correct the problems within the current mental health system, the authors of the report stated that,

"all services must give consumers and their families a "seamless continuum" of care. This means that care must be easy to identify and easy to get, and all services must be connected to each other. It must be designed, not for caregivers, but for consumers and their communities" (Summary of the Mental Health Task Force Report, December, 1993).

There was a perception that the system somehow was organized to accommodate the needs of caregivers, and that consideration had to be given as to how to better meet consumer and community needs.

The report was comprehensive in its identification of major problem areas and recommendations for service improvement. The first problem described was the inadequacy of coordination within the mental health system. Another problem found within the system was the lack of comprehensive and continuous services. It was also noted that there were problems with system-wide evaluation, and that there were serious funding and resource inequities within the system. Finally, the report identified the many human resource problems in the current system ("Final Report of the Mental Health Task Force", Regional Health Board, June, 1993).

Among the recommendations was the continuation of the Mental Health Task Force, to ensure ongoing community input, and the development of a framework to begin to negotiate transfer of mental health services from the province to the region. The report recommended,

"that the Mental Health Task Force stay intact as an interim Mental Health Regional Advisory Committee (IMHRAC) until Community Health Councils are formed", and "that the Regional Health Board form a Mental Health Transition Team to work with them [IMHRAC] for the duration of the transition period to implement the transfer". ("Final Report of the Mental Health Task Force, Regional Health Board, 1993, p. vi and xi).

The Regional Health Board accepted the report of the Mental Health Task Force in June of 1993. This is significant, as the Regional Health Board's acceptance meant that the Mental Health Task Force's report (including its recommendations) met the standards or interests of the Board. The Board soon began acting upon the recommendations, first setting up the Interim Mental Health Regional Advisory Committee (IMHRAC) to provide advice regarding concerns within the mental health community and coordinate regional mental health initiatives. The Interim Mental Health Regional Advisory Committee, chaired by a Regional Health Board trustee, was directly accountable to the Board. Its terms of reference state:

"As an external committee of the Regional Health Board, the Interim Mental Health Regional Advisory Committee will facilitate the linkages between the implementation working groups recommended in the Mental Health Task Force Report and advise the Board on implementation issues" (Terms of reference of the Interim Mental Health Regional Advisory Committee, July, 1993)

The Transition Team Steering Committee (TTSC), also recommended in the Mental Health Task Force's report, was formed in August of 1993, as a subcommittee of the Interim Mental Health Regional Advisory Committee. Its roles were to provide operational advice regarding the transfer itself, through the inclusion of representatives of provider groups and organizations which would be affected by the transfer of authority for mental health services in the region, and to undertake negotiations with Ministry staff concerning transfer of mental health services to the region.

"The Transition Team was charged, by the Board, with coming up with the process by which the parts of

the mental health service apparatus would be transferred, as far as governance [was concerned]" (Interview with a Regional Health Board trustee, June, 1995.

The members of the Transition Team were clear about their sub-committee's role, which was to ensure immanent transfer of mental health programs and services to regional control.

"[A TTSC member] asked for and received consensus from the TTSC that the first priority of the TTSC would be to identify options and make recommendations to the [R]HB regarding moving government services to a regional operating authority under the umbrella of the [R]HB by April 1, 1994" (Minutes from the TTSC, October 20, 1993).

By this time, the Regional Health Board was in the midst of developing its regional governance and management plans. In the Fall of 1993, the Regional Health Board decided that rather than becoming a direct employer of mental health services staff, the Board would accept responsibility for regional governance, planning, and resource allocation.

"It has never been the [Regional] Health Board intention that direct service Ministry of Health employees would be transferred to become employees of the Board. The Trustees of the Regional Health Board decided at a planning retreat in October, 1993 that they did not want to become a large health corporation and direct employer of all health care workers in the region" (Regional Health Board, "Summary of key points regarding the transfer to the RHB of Mental Health and Alcohol Programs", October, 1994).

I have come to see this as an important moment in the story I'm about to tell. This decision meant that the Board would govern rather than manage, in relation to health care services and programs. As I shall show, the Board later had to review this decision during their mental health transfer negotiations with the Ministry of Health.

By February of 1994, the Transition Team Steering Committee indicated to the Ministry of Health that they were prepared to begin transfer negotiations. For some time now, the Mental Health Task Force and its subcommittees, IMHRAC and the TTSC, had been doing their work. The Board felt that they understood regional issues and concerns, and were clear regarding regional priorities vis-a-vis mental health transfer. In a letter to the Deputy Minister of Health, the Regional Health Board chairperson wrote,

"For the past eighteen months the [Regional] Health Board has been working on a wide range of

community mental health issues with consumers, family members and service providers in preparation for the transfer of authority, responsibility and resources for Mental Health Services and Alcohol and Drug Programs from the Ministry of Health to the [Regional] Health Board. We are now ready to establish formal negotiations for the transfer of authority. Included in this process is the acquisition of a Mental Health / Alcohol and Drug[4] manager to be responsible for the operations of those services in the region" (from a letter to the Deputy Minister of Health, from the Regional Health Board chair, February 24, 1994).

In their preparations for transfer, the TTSC had identified the need for an interim manager for Mental Health and Alcohol and Drug programs, in order to effect regional control within a reasonable timeframe. This would mean that the Board would be responsible for managing regional mental health and alcohol and drug programs on a temporary basis, despite their decision to be a governing body, rather than a management body. However, this seemed a necessary step to the Board, to effect local control of mental health services and programs within the next year.

In attempting to outline the parameters which would allow for regional control of mental health services and programs, the TTSC had come to realize that central to transfer was the issue of "who" would control the negotiations and transfer - the Board, or the Ministry? A Regional Health Board staff member put it this way,

"The ministry wanted to develop an internal group [internal to the Ministry] to "do" the transfer. The Board said no, that they needed to have control of the process. The Mental Health Task Force had developed recommendations, including that of a transition team to "do" the transfer (Interview with a Board staff member, December, 1994).

Local control, both of the negotiations and of the mental health system, was important not only to the Board, but also for community members who had been participants in the mental health reform process.

The process of negotiations dragged on for more than a year. During this time, the Board continued to inform and involve community agencies regarding the mental health transfer process. Discussions with agencies consisted of the nature of the problems to be solved, and the kinds of decisions to be taken, including how staff were to be managed. Agencies were also interested in discussing the sort

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4 The Ministry of Health's Regional Alcohol and Drug Programs (ADP) were included in the transfer process at this time, such that any negotiations for transfer included these services and programs, as well as those of mental health.

of governance or management which the Board envisioned as best meeting regional needs. Finally, towards the end of 1994, it became evident to the Transition Team Steering Committee that the Ministry of Health was not moving as quickly to "transfer" as the community group wished.

The Board Merges the Mental Health Transfer with "New Directions"

In their final report, the Mental Health Task Force members identified the challenge of finding a way to link mental health reform to "New Directions" ("Summary of the Mental Health Task Force", Regional Health Board, 1993). Both were tasks that the Board had undertaken. While the provincial mental health consultation process had been initiated long before "New Directions" was announced, the Board, by 1993, was also involved with "New Directions". The Mental Health Task Force wrote,

"[t]he second challenge was how to link the work of the task force to planning underway in response to the Ministry of Health's "New Directions for a Healthy British Columbia" document released in February 1993" (Regional Health Board, "Summary of the Mental Health Task Force Report, December, 1993, p. 2).

This linking seemed an important step to the Regional Health Board, as it would formally entrench the participatory basis of the mental health reform process in official provincial government policy.

The question remained, though, of how to actually relate the work undertaken by the Mental Health Task Force, and the Board subcommittees which had been developed to actually "do" the transfer, with the "New Directions" process which had overtaken mental health reform. Both tasks were assigned to the staff of the Regional Health Board. The solution that presented itself was to merge the mental health transfer with the "New Directions" process.

"[t]he task force has been aware of, and to some degree involved in, many of the above [actions and developments of the Regional Health Board] and has attempted to develop a plan that will continue to connect and build on these initiatives as they evolve. This plan cannot be seen in isolation but rather is complementary to the overall plan for health services outlined in the Ministry of Health "New Directions for a Healthy British Columbia" document, other plans being developed by the [R]HB, and the ongoing work of the people within the current system" ("Final Report of the Mental Health Task Force", Regional Health Board, 1993, p. 2).

The Board clearly saw "New Directions" and the mental health transfer process as interrelated or parallel workings, and as is alluded in this quote, both were built on the strategy of citizen participation.

The methodologies of citizen participation and community development were already being used in transferring mental health service delivery and administration to the region, and in the various Board initiatives such as the efforts to organize and develop governance and management frameworks. A staff member explained the Board's understanding of the relationship between citizen participation and community development in this way,

"Although participation is a part of community development, it is not, in itself, community development" (Interview with Regional Health Board staff, December, 1994).

The Board considered citizen participation to be central to community development, its chosen way of working.

One Board document described the importance of community development to "New Directions" in this way,

"[b]ringing people together from the [community], community agencies providing health services and the Ministry of Health is a major role of the [Regional] Health Board. This process of community development helps to educate, inform and coordinate a range of planning issues and activities related to the unfolding of the "New Directions" program" ("What it's all about", Regional Health Board newsletter, December, 1994).

Contained within these statements is the notion of participation - of members of the community, community agencies and the Ministry of Health. However, more than participation is being described; what is being advocated is a process of "developing" and planning for community interests and concerns, through education, information and coordination. That is how the Regional Health Board understood their job of enacting "New Directions".

The Board's decision to use the methodologies of citizen participation and community development appear at first glance to be compatible with the "New Directions" emphasis on participation. The documents which establish "New Directions" refer often to citizen participation, with statements such as the following:

"We must achieve more public involvement...by providing more opportunities for local decision-making by citizens" (Ministry of Health, "New directions for a healthy British Columbia", 1993, p. 13).

While there are numerous statements in regards to participation in the "New Directions" document itself, there are no references to community development. However, a "New Directions" supporting document contains reference to "community development" in a section entitled, "How do communities and regions get started?". The document states,

"[m]uch work is required for a community to set up a community council and accept full authority for the management of health services. The developmental process will differ in each community - some communities have done quite a bit already and may have structures and processes in place. These may have to be adapted or expanded. Some communities may have had prior experience with citizen involvement or community development approaches that they can build upon. Other communities may just be getting started, and will require a great deal of support in community development" ("A guide for developing community health councils and regional health boards, Ministry of Health, 1993, p. 9).

The intent of the terms community development and citizen involvement being used in this Ministry of Health document is not entirely clear. At the very least, there appears to be acknowledgement of community development as a methodology given some level of acceptance by policymakers within the Ministry of Health during the early stages of regionalization.

At first glance, the decision by the Regional Health Board to favor citizen participation as part of its overall community development strategy appeared to be compatible with "New Directions'" participation focus. The Ministry's lack of emphasis on community development was likely an early "warning bell" that the Regional Health Board and the Ministry of Health held different ideas about how to proceed with "New Directions". As I shall show in the next chapter, the Regional Health Board and the Ministry of Health not only had different ways of thinking about participation, they had very different practices or ways of operationalizing "New Directions".

# CHAPTER FOUR

## SOCIALLY ORGANIZED TROUBLES IN THE MENTAL HEALTH TRANSFER

In this research, I am working with the assumption that my informants' narratives of the regional mental health transfer negotiation process reveals their active involvement in the social relations in which their work is embedded. The "troubles" which are outlined in this chapter are the "result of complex interactions between individuals and the institutionalized social relations" (Jackson, 1984, p. 3). As I will show, the "troubles" experienced by staff and trustees of the Regional Health Board as they attempted to negotiate the mental health transfer arose out of the Regional Health Board and Ministry of Health's competing versions of how to organize and manage in a manner congruent with "New Directions".

I begin this chapter my describing and analyzing the Ministry of Health's organizational structure and practices enacted to support "New Directions". I then show that these changes undertaken by the Ministry of Health are congruent with their ideas and practices of public administration. Later, I show how the Board staff and trustees went about their "New Directions" work in ways compatible with community development. Data for this chapter draw on interviews with Ministry of Health officials and Board staff and trustees, as well as documents, including public administration texts.

### Ministry Reorganization

A number of "troubles" plagued the transfer process, leading to feelings of frustration and uncertainty on the part of Regional Health Board staff and trustees. In February of 1994 and early in the negotiation process, the Ministry of Health underwent a restructuring exercise, ostensibly to support "New Directions" and "provide the necessary structures for decentralization and regionalization" ("Restructuring News", February, 1994). The Board trustees and staff, however, did not experience restructuring as helpful to their regionalization efforts. Rather, they found that the restructuring of the Ministry's bureaucracy hindered the mental health transfer process. The Ministry wrote that restructuring would,

"reflect the new, broader approach to health, ... facilitate the move to regional and community decision making, and enhance accountability" (Ministry of Health, "New Directions", 1993, p. 16).

Hence, the Ministry re-organized its areas of responsibility from a program area focus to a functional focus. According to the Ministry of Health documents, this move to a functional focus involved "a number of changes to divisions and reporting relationships" (Ministry of Health, "Restructuring News", November, 1993, p. 2).

Previously, program and service areas had been organized into divisions such as Community and Family Health, Care Services, Strategic Services, Policy and Planning, Emergency Health Services, and Facilities Construction, to name but a few. Now, nearly all health services would be undertaken by a division called "Regional Services", while all "New Directions" leadership and support would be provided by "Strategic Services". All financial and operational management would be conducted by "Corporate Services". The restructured version of the Ministry of Health is depicted in Figure 1 of Appendix A.

According to the Ministry, the Regional Services Division would provide care and programs while the Strategic Services Division would ensure support for the successful implementation of "New Directions". From the new organization chart, it appears as though the Ministry differentiated the responsibility for implementation of "New Directions" from the management and sustenance of the current system of services. While the Ministry's new organization chart contains re-aligned areas of senior management responsibility, it maintains a particular organization structure, familiar to most modern bureaucracies of separate and distinct divisions, with hierarchical reporting relationships. I've picked a quote that demonstrates exactly this point.

"Bureaucracy, for example, is a form of organization which is characterized by a strong division of labour, a clearly defined hierarchy, detailed rules and regulations, and impersonal relationships. It is the classic organizational framework for public sector organizations" (Cassidy, F., 1989, p. 58).

As is evident from the organization chart's linear nature, traditional public administration ways of hierarchically structuring or organizing for accountability remain intact with the Ministry's new organization chart. This is visible in a number of ways. Areas of work are seen as distinct and separate;

"New Directions" implementation is separate from current health care system management and operations. Also, hierarchical reporting relationships which delineate upward accountability remain a central feature of the organizational chart.

A senior Ministry of Health official explained the Ministry hierarchy in this way,

"Ultimately the deputy ministers are responsible to the Minister of Health for decisions and actions taken within the ministry. There are four assistant deputy ministers, responsible for program areas in the ministry. The delegation of authority goes down to them for those particular issues. They, in turn, have a number of executive directors who report to them. That's accountability" (Interview with a senior Ministry of Health official, July, 1995).

As this Ministry official indicated, this hierarchical structuring, evident in public administration worldwide, has arisen out of particular ideas around accountability. Accountability, then, works in a particular way. Here is one bureaucrat's view of the way that accountability affects even informal discussions.

"If I'm going to give you my opinion or talk about other areas of the ministry, I'm not going to do that in quite the same way as I would about services in my division. Because one of the **practices** which I think is good is having to let my boss know what is going on, just in case there is some fall-out from it, and there often is" (Interview with a senior Ministry of Health official, July, 1995, bold face emphasis added).

This description of accountability carries with it the idea that there may be blame or responsibility for words or actions, and that "the buck has to stop somewhere". Also contained within this description is the notion that accountability, in the form of letting your boss know what is going on, has specific **practices** or ways of working, which enact it.

## Public Administration as Practice

In this next section, I explore this notion of "practice" in relation to public administration as a management technology. Ursula Franklin, a noted author on technology, writes about **practice** or the way of doing something, as technology, the organization of work and of people. In her book, The real world of technology, she writes,

"[t]echnology 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, p. 12).

Franklin discusses the development of modern bureaucracy not only as a technology, or a way of organizing work and people, but as a prescriptive technology. Prescriptive technology, according to Franklin is "specialization by process" (p. 20) meaning that the "work is organized as a sequence of separately executable steps" and the "control over the work moves to the organizer or manager" (p. 23).

"After the industrial revolution, when machines began to be added to the workforce, prescriptive technologies spread like an oil slick. And today the temptation to design more or less everything according to prescriptive and broken-up technologies is so strong that it is even applied to those tasks that should be conducted in a holistic way" (Franklin, 1990, p. 24).

Franklin points out that prescriptive technologies such as public administration practice, pervasive in modern society, are "designs for compliance" (1990, p. 23).

Public administration ideas and practices described here and practiced within the Ministry of Health have been introduced into the execution of government, forming an organizational framework through which much of public enterprise is carried out and through which democracy is seen to be exercised.

"Public bureaucracy is the system of authority, people, offices and methods the government uses to achieve its objectives. It is the means whereby the practice of public administration is carried on..." (Kernaghan & Siegel, 1991, p. 4 & 5).

The ideas and practices of public administration are intended to ensure that the bureaucrat or public administrator retains neutrality and is not able to misuse powers at his or her disposal. In the following quote, duGay (1994) elaborates on this idea, crediting Weber with its origins.

"Weber's stress on the 'impersonal', 'functional' and 'objective' nature of bureaucratic norms and techniques refers simply to the setting aside of pre-bureaucratic forms of patronage" (duGay, 1994, p. 140).

These notions of objectivity and impersonality, central to public administration are taught through formal

educational programs to students of public administration in programs aimed at "train[ing] prospective practitioners, conduct[ing] research, develop[ing] theory, and consult[ing] with organizations" (Cassin, 1980). Textbooks, such as Public administration in Canada (Kernaghan and Siegel, 1991) are devoted to the topic of public administration and inform potential new public administrators as well as mid-career administrators taking courses.

> "The ethical attributes of the good bureaucrat - strict adherence to procedure, acceptance of sub- and superordination, commitment to the purposes of the office and so forth.....should be viewed as a positive moral achievement in their own right. They represent the product of particular ethical techniques and practices through which individuals develop the disposition and ability to conduct themselves according to the ethos of the bureaucratic office" (duGay, 1994, p. 139).

However, it is not only public administrators who learn how to "do" public administration. Ng (1988) in her book The politics of community services shows how counsellors in an employment agency for immigrant women, despite their activist origins, became participants in the process of producing low-paid workers for industry. Ng argues that the introduction of funding and reporting requirements by the state, and the development of a hierarchical organizational structure organized the work of the counsellors so that they became active participants in administering the state and industry-sponsored employment program.

Franklin, too, believes that ordinary people have become inculcated to the practices of bureaucracy, accepting it as normal and inevitable. She writes,

> "[t]he acculturation into a culture of compliance built on the willing adherence to prescription and the acceptance as normal of external control and management make bureaucracy possible" (Franklin, 1990, p. 116).

As I shall show, these ideas and practices of public administration or modern bureaucracy not only affected the ideas and work of officials in the Ministry of Health, but remained taken-for-granted by trustees and staff of the Regional Health Board.

## The Ministry Declares that Community Development is Done

The Ministry of Health had other ideas of how to make changes to support "New Directions", in addition to restructuring. They made changes to the personnel in senior positions and sped-up regionalization timelines. As an official in the Ministry of Health explained, significant attention had been given to matching the "right" people with the new positions.

"My own notion about this is that you have to have the right people in the job to have that [good management] happen. And there are the right people in the jobs now [following the Ministry's reorganization]" (Interview with a senior Ministry of Health official, July, 1995).

However, this change of personnel in key positions within the Ministry of Health was not seen as helpful by the transfer negotiating team.

New timelines for Board and Council work, and for citizen participation were also announced. The open-ended process of citizen participation originally envisioned in the "New Directions" documents and by the Board was shortened, as the Minister of Health announced speeded up timelines, indicating that it was time to move forward more quickly with the process. As a senior Ministry of Health official announced at a public forum,

"We've broken down the barriers to re-structuring in the Ministry. The community development stuff is done. It's time to get on with things" (Public Panel discussion on "New Directions", February, 1994).

This comment suggests a view within the Ministry of Health that both restructuring and community development are definable and finite processes, and that they had already been accomplished. I contend, however, that this was an early warning signal that officials in the Ministry of Health had a very different view of citizen participation and community development than the Regional Health Board. I will return to this point shortly.

Public Administration and Participation

Through "New Directions", public administrators were being challenged with simultaneous demands to be more accountable and effect cost-savings through efficiency, and at the same time, provide citizens with opportunities for meaningful and significant participation in planning, organizing and

decision-making.

Citizen participation may be considered cumbersome and inefficient by public administrators when contrasted with public administration practices which use hierarchical, rule-bound forms of planning or decision-making and where there is acceptance of sub- and super-ordination.

"Consultations with citizens, citizens' groups, and advisory bodies can be extremely time-consuming and, therefore, an inefficient use of the time and energy of public officials. Such consultation can also lead to less efficient and effective government by causing delays in the making of decisions and the delivery of programs" (Kernaghan & Siegel, 1991, p. 463).

When increased levels of efficiency are being demanded of governments in general and public administrators specifically, processes which require significant amounts of the time of public administrators, seem, from that perspective, to be particularly inefficient.

However, it is not only the time element which is deemed to result in inefficiency. Within public administration is the notion of the public administrator as "expert" practitioner in the machinations of government.

"Efficiency and effectiveness can be further reduced if "expert" public servants are obliged to take undue account of the views of "amateur" citizens" (Kernaghan & Siegel, 1991, p. 463).

This expert-driven model of work stands in direct contrast to the notion of citizen participation where the input of ordinary citizens, as experts of their own lives, is valued.

In order to effect participation (as in the case of this study) public administrators may be asked to take on new roles, such as facilitators of participation. Not only are they unlikely to have experience in ascertaining and incorporating the views and ideas of the public into policy, they are also unlikely to find the transition from expert to facilitator easy.

"Movement along this spectrum [of participation] is difficult in itself..... As public involvement becomes more complex, the policy role of the public servant changes from subject matter expert to communicator and consensus builder" (Langford, & Prince, 1994, p. 40).

As citizens gain a hand at policy making, and as public administrators are faced with new and different ways of working, contradictory elements of public participation versus accountability and efficiency emerge. Hence, public administrators may design and formulate consultative processes, rather than processes which involve people in more meaningful forms of participation.

"As a result, public servants and service agency employees are regularly confronted with the challenge of designing public consultation processes that broaden representation beyond the boundaries of traditional interest groups without hopelessly impairing the efficiency of decision making" (Langford, & Prince, 1994, p. 20).

It is hardly surprising, then, that a senior public administrator (such as the one I quoted earlier) considered the community development work to be done, while the Board and community considered community development to be an ongoing process. An ongoing process would "hopelessly impair the efficiency of decision-making" and would make it nigh-impossible for public administrators to meet their simultaneous demands to be more efficient administratively and fiscally, yet more participative.

"Chaos" Reigns

While all of these changes were undertaken by the Ministry ostensibly to support the implementation of "New Directions", Regional Health Board staff and trustees found that these changes actually worked to seriously inhibit the transfer negotiations. This occurred in spite of written and verbal reassurances of the Ministry of Health's commitment to "New Directions'" explicit participation focus. At this point it seemed as though the troubles could be attributed to the considerable disarray in the Ministry of Health. As a Board trustee noted, "The Ministry of Health, at that point, was in a state just short of chaos" (Interview with a Board trustee, June, 1995).

A staff member describes what it was like, dealing with a reorganized Ministry:

"The "New Directions" process was speeded up, there was the Ministry's internal reorganization, and the "stovepipes" changed. Instead of acute care and community services, we were now dealing with Strategic programs and Regional programs. Suddenly, everyone, all the people involved, were different" (Interview with a Board staff member, December, 1994).

While the changes - restructuring, personnel changes, and speeded-up timelines - were frustrating, they

provided an explanation to the negotiating team. They reasoned that the slowness of the negotiations could be attributed to the internal turmoil in the Ministry as people readjusted to new positions, timelines and responsibility.

The Regional Health Board's Community Development Work

In the previous section, I introduced the notion of practice in relation to the ways that public administration is carried out in a democracy. The Board, too, developed specific practices or ways of working in order to reflect its commitment to principles of community development. A Board informant indicated that much emphasis was placed upon the community development principles of inclusiveness and participation, as well as on ways to enhance and encourage participation. As a result, mental health consumers and their families were involved in the process, as were people who worked within the mental health system. Unlike traditional processes, attention was being given to consumers and their families, not at the expense of caregivers, but in addition to caregivers.

"the Mental Health Task Force involved people who had been trying to use the service, their families, advocates, and people who worked in the system" (Interview with a Regional Health Board trustee, June, 1995).

Not only did the Mental Health Task Force suggest that it was important to encourage participation by people affected by the mental health system, it was also necessary to understand their different experiences and perspectives, and consider the complexities within these groups. This sort of process, where diversity of interests and experientially-gained knowledge are valued, is central to community development and stands in direct contrast to processes which value expert-driven knowledge and the determination of one officially-sanctioned view of events. In the Mental Health Task Force report, the authors explain it this way,

"A major challenge for the task force has been to formulate recommendations that respect and foster diversity and uniqueness while creating the linkages between the multiple service areas. The task force has engaged in this struggle and individual members have gained a greater understanding of one other's perspectives through the process" ("Final Report of the Mental Health Task Force", Regional Health Board, June 11, 1993, p.2-3).

Participants were gaining an understanding of the experiences of consumers, their families, and advocates, as well as of workers in the troubled mental health system. Similar and divergent interests were being acknowledged, recognized and explored as people participated in the process.

Opportunities for meaningful ways of participating had to be developed. The Interim Mental Health Regional Advisory sub-committee remained broad-based and open to new membership of consumers, families, and providers. People were free to come and go from the process, as opportunities for participation, rather than consistency were emphasized. By doing so, there was acknowledgement that people with mental health problems might have difficulty with the consistency that a traditional committee structure would entail.

As well, meetings were held at places and times which would be more likely to attract people, especially those with few opportunities to participate. Hence, meetings were held in hospital-based psychiatric facilities, community agencies, and rooming houses. Costs such as public transportation and child care were covered, to promote access by people with fewer resources (Interview with a Board staff member, December, 1994).

Local control and ownership of the process of mental health transfer was important to the Board. The Board's idea was that services should be planned, organized and managed as close to the point of delivery as possible instead of in what one staff member described as "ministry back rooms".

> "People, regular people, are airing differences of opinion, which has never been a part of an open discussion before. Unless we can being these [contentious] issues out, they won't get fixed. They need to be discussed in an open forum. For too long things have been discussed in ministry back rooms, where solutions have been worked out to problems created by the ministry" (Interview with Regional Health Board staff members, December, 1994).

Their argument was that local planning and organizing had for too long occurred outside of communities. It was time to move planning and decision-making "closer to home".

Board staff and trustees considered ordinary citizens as capable of identifying and understanding their community concerns and developing potential solutions to these concerns.

"Community plans and priorities are a starting point for decision-making. If "New Directions" is going to work, it is because communities are going to find out their priorities, and use these in decision-making" (Interview with Regional Health Board staff members, December, 1994).

The "expertise" of ordinary citizens in regard to those matters affecting their lives, then, would provide communities with insights necessary to locally-responsive planning and decision-making.

The Board, with its various subcommittees, had undertaken to develop a community-based plan, through citizen participation and community development, and in relation to regional mental health concerns.

"The immediate goal for the [R]HB is transfer of responsibility for resource allocation for all mental health and addictions services in the region [to the region]" ("Summary of key points regarding the transfer to the [Regional] Health Board of mental health and alcohol and drug programs", Regional Health Board, October, 1994, p.1).

Through this process, the Board had come to understand that mental health services in the region were in disarray, and in order to improve mental health services and programs, regional control was necessary. This was at the heart of the mental health transfer process.

Both the Ministry of Health and the Regional Health Board developed practices which they understood to be compatible with enacting the "New Directions" explicit participation focus. For the Ministry of Health, this meant internal restructuring to accommodate the new work areas outlined in "New Directions". For the Regional Health Board, community development, with its fundamental notion of citizen participation, remained central to both their mental health reform process and "New Directions" work. As I shall show when I discuss the "troubles" in greater detail, the difficulties encountered by the Board negotiators were a visible example of the competing and incompatible ideas and practices of the Ministry of Health and the Regional Health Board.

A Struggle for Control - the Board Presents its "Org. Chart"

One instance that illuminates the nature of the trouble between the Board and the Ministry of Health was the introduction of the Board's proposed governance structure to Ministry staff. The Regional

Health Board had produced a plan for a governance structure that, in keeping with Board practices, would provide the flexibility and responsiveness necessary to understanding and meeting the region's health care needs and concerns.

The Board's organizational chart was developed to depict the relationships between the Regional Health Board and the Ministry of Health, provider organizations, and different advisory groups, as well as to reflect the internal working relationships between the Board and staff. Working from a community development methodology, Board trustees and staff had developed particular ways of working or practices which they attempted to reflect in their organizational chart.

The appearance of the Regional Health Board's organizational chart is quite unlike the Ministry of Health's restructured organizational chart. While the Ministry's traditional hierarchical organization shows separate and distinct divisions, with vertical or linear lines of reporting, the Board's organizational chart does not. Rather, there are a series of figures and arrows, depicted in such a way as to give the impression of a three-dimensional view and indicate a sense of minimal hierarchy.

The Board produced an intra-organizational chart (Figure 2, Appendix A) and inter-organizational chart (Figure 3, Appendix A), in order to describe both internal organizational relationships as well as connections and relationships with the community and other agencies. Regional Health Board staff and trustees saw it as essential to attempt to depict their interrelationship with other organizations and the community in a non-hierarchical way. Being responsive to the community called for collaborative, not authoritative relationships (Interview with Regional Health Board staff member, December, 1994).

Board staff noted that the Board's organizational chart, submitted for the designation[5] process, became a source of contention during mental health transfer discussions. This seemed to be yet another area where Ministry of Health personnel did not understand the Board and its community planning process.

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5 In order to become "official", each regional health board in the province was required by the Ministry of Health to fulfill certain requirements and submit supporting documents. This process became known as the "designation process".

"People in the Ministry don't "buy" into the organizational structure in our designation document. A different person everyday shoots holes in the structure. Does every Ministry of Health bureaucrat need to "ok" the structure? They say they're not going to transfer mental health because they don't think our organizational structure will work" (Notes from a Regional Health Board Staff meeting, September 28, 1994).

As members of the Board's negotiating team indicated, they dealt with not one, but many ministry officials at different levels of authority, all of whom took the opportunity to describe their discomfort and misgivings with the Board's governance structure. Throughout this intense ministerial scrutiny was the underlying message that all who examined the governance documents had to find them appropriate in order for the process to continue.

"The organizational chart that we developed is open for interpretation as it is relationships between bubbles. People's personal experience and philosophy may mean that they see it and interpret it differently. But that is the reality of our whole development. However it is totally gibberish to the Ministry. It gets talked about in different ways. My colleagues and I [involved in the mental health transfer negotiations] have spent the last six months with the Ministry of Health going over and over the "org chart". Things will be brought up that are included in the organizational chart, and yet people haven't realized or recognized this because it is just not "there" for them. There are things in that "org chart" that people do not physically see, it doesn't mean that they will like it if they do see it. However, they must see it first" (Interview with Regional Health Board staff, December, 1994).

In order to "see" a chart as representing acceptable organizational relations requires that the observer has a mode of organizational action in his or her head, and "finds' its" representation in the text. The acceptable model of organizational action held by Ministry staff (and exemplified in their restructured organizational chart) is one which reflects and accomplishes the hierarchical relations of conventional modes of bureaucracy. No matter how much "going over and over" the meaning of the Board's chart, the Ministry staff were not going to be convinced of the adequacy of the Board's governance model. The organizational chart failed the Ministry's test, which is the textual representation of governance with features that public administrators (ministry officials) know as correct and adequate, and which are reflected in their own Ministry of Health organization chart.

I argue that these are instances of a very basic mismatch between a Board involved in a community development planning process and a Ministry proclaiming its interest in citizen participation, but whose officials are required to work in other modes of operation. The instances identified here reveal

the experiences of the Board trustees and staff as they tried to practice and actually "do" things differently, in what they understood and seriously undertook in the spirit of "New Directions". Through a process of citizen participation in the planning of mental health services, the Board's staff and trustees felt confident that they had ideas of how to positively change regional mental health care. As they tried to make these changes, they met a variety of troubles or difficulties, which they experienced as frustrating and confusing, and which made evident that a struggle for control of the process was emerging.

The Troubles Continue - Topics Disappear

The negotiations for transfer of mental health services to the region ground on for months, with nothing being altered in the day-to-day work in the troubled mental health system. The Transition Team Steering Committee began to feel they were making no progress. Hope was revived, when in April of 1994 the Ministry of Health appointed an official to be responsible on behalf of the Ministry for discussing transfer with the Regional Health Board. The mental health community and Board negotiating team felt this, while tardy, was a significant development.

"So, in about April, 1994, the Ministry of Health handed their piece of negotiations to our new contact [the newly appointed official], who was in the Regional coordination area [of the Ministry]" (Interview with a Regional Health Board staff member, December, 1994).

There was a sense of expectancy that now they could actually get decisions and action on their recommendations, as one person in the Ministry of Health would have responsibility for the transfer negotiations.

This appointment was exceptional in the minds of Board staff and trustees because it seemed to accomplish the first linking by Ministry personnel of the transfer process with "New Directions". While the Ministry of Health's transfer official (the Board's new contact person) was located in the Ministry's Regional Services Division, which is responsible for health services, and not in Strategic Services, the division responsible for "New Directions", he seemed to clearly link his work related to the mental health transfer negotiations with regionalization and "New Directions". The Board people felt optimistic about

this, thinking it would further the transfer process.

"The best thing about this was his [the new official's] consistency. He [the Ministry of Health contact] has spent a lot of time communicating things within the Ministry. Mental health is not something that he has expertise with, however, he was trying to move it along in terms of "New Directions". This was the first real linking [by the Ministry] of mental health transfer with the "New Directions" process" (Interview with a Regional Health Board staff member, December, 1994).

While all of these indications seemed favourable for the transfer process, by the Fall of 1994 it was apparent to members of the Regional Health Board, the Transition Team Steering Committee, and the Interim Mental Health Regional Advisory Committee, that something was wrong. Despite Ministry assurances of being committed to transferring authority, the transfer process was not moving forward. Some of the Regional Health Board staff and trustees began to blame Ministry of Health bureaucrats for sabotaging the process.

"The bureaucrats are sensing their empires are crumbling. This is their last kick at the can" (Quote from a Regional Health Board trustee, Regional Health Board meeting, August 10, 1994).

This Board informant is suggesting that bureaucrats who might have less control over management of the health care system following regionalization were intentionally preventing the process from moving forward. However, I contend that this was not a case of the process being intentionally subverted by officials in the Ministry. I argue that the trouble related, rather, to Ministry officials carrying out their work in ways compatible with traditional public administration ideas and practices. This argument is highlighted in the following examples.

Trustees and staff of the Board were ready to get Ministry approval of their plans and to get on with the actual mental health system changes. In order to do so, the negotiating team held many meetings with their Ministry contact. During discussions with the Ministry contact, the negotiating team felt frustrated by what they described as "disappearing" topics. Board trustees and staff had the experience of presenting topics at meetings with Ministry of Health personnel, for instance, issues that may have needed an okay from the Ministry. What happened again and again was that those topics or requests "disappeared" from the negotiating table, perhaps later reappearing on agendas elsewhere, but resulting in

"no progress" for the transfer of mental health services.

PL: "What happened during meetings with your Ministry of Health contact?"

Staff member: "Well, issues would be raised. Then he [the Ministry of Health contact] would take them back to the Ministry. Then, they would raise more questions and issues, and so on and so on. Items and issues would get siphoned off to various committees [in the Ministry] and then disappear. These were not negotiations, but discussions. Our contact would say that our meetings were good, because all the things that the Ministry had to deal with were being identified for them. However, it did not move our process with the Ministry forward" (Interview with a Board staff member, December, 1994).

From this statement, it is apparent that the experience of having important topics "disappear" from discussion was frustrating for the Board negotiating team, and perhaps was linked to the notion that ministry bureaucrats were intentionally subverting the whole mental health transfer process. However, I argue that as frustrating as this experience must have been, it is an example of the idea of hierarchical decision-making being practiced within a public administration framework.

According to Kernaghan and Siegel, hierarchical structures can ensure that decision-making occurs at "appropriate" levels.

"Hierarchy in administration is a prime safeguard of administrative responsibility in that it forces important decision to higher levels of determination or at least higher levels of review where perspectives are necessarily broader, less technical and expert, more political" (Kernaghan and Siegel, 1991, p. 331).

In the instance of the "disappearing topics" there is evidence of the Ministry's actual decision-making practices. The Ministry contact would take requests for decisions from the TTSC back to the Ministry of Health, where they would be deliberated upon in the "appropriate" work area, or by the appropriate senior ministry official, as determined within the Ministry. Often, it would be quite some time before decisions thus made within the Ministry would be made known to the Board's negotiating team. While this approach to decision-making seemed to make sense to Ministry officials, it clearly made no sense for the Board negotiating team, and served to slow the transfer negotiations to a virtual standstill.

In the following similar example, the routine public administration practices around decision-making and authority are once again visible. In this situation, the Board negotiating team came to understand that the Ministry of Health was setting up "barriers" to progress in the negotiations.

"Our ministerial contact would leave a meeting with a number of tasks and clearances that we felt we needed to get and would come back with a position or something that needed the approval of our committee. The committee would do its work. Some things would have to come to the Board. Then, we would sit back, relax, thinking that we were set to go. The next meeting, there would be another, well, I hesitate to call them barriers. There would be another hurdle as we were getting closer and closer, and narrower and narrower in the discussions" (Interview with a Regional Health Board trustee, June, 1995).

Members of the community and Board began to understand that no concrete decisions could be made. They began to understand that this represented more than just a slow process when nothing they did got any real response from the Ministry of Health. Later, one member of the Board's team said:

"Our contact in the Ministry has worked very hard at this. He was just never given the authority to negotiate. He's an intermediary. He talks to us, then he goes back to the Ministry. We're not in negotiations as no one in the Ministry has the authority to do anything; we're in a process of discussion, of clarification" (Interview with a Regional Health Board staff member, December, 1994).

This instance provides us, yet again, with insights into Ministry of Health decision-making practices. Given that the Ministry of Health continued to be organized around traditional notions of upward accountability, the Ministry negotiator's job would be to siphon off information and requests for decisions to the appropriate levels and positions within the Ministry. The actual decision-making authority continued to reside in its traditional locales - in senior levels of the Ministry of Health bureaucracy.

## The Taken-for-Granted Nature of Public Administration Practices

The Regional Health Board trustees and staff involved in the mental health transfer negotiation articulated their experiences of frustration and dismay at the slow pace of the process. As I have described, they had many explanations for their experiences, from chaos within the Ministry, to "bad faith" negotiations and intentional subversion by Ministry of Health officials. However, the Ministry's actual practices remained taken-for-granted by trustees and staff of the Regional Health Board.

The work of Franklin (1990) and Ng (1988) is helpful in understanding why Ministry of Health public administration practices remained taken-for-granted. Franklin notes the all-pervasive organizing power of the bureaucratic model stating,

"[t]he acculturation into a culture of compliance built on the willing adherence to prescription and the acceptance as normal of external control and management make bureaucracy possible" (p. 116).

The notions of pervasiveness and acceptance as normal are important, as the Board also employed traditional public administration practices. Regional Health Board staff and trustees employed task-specific sub-committees, elected chairpersons, held meetings, and documented meetings in minutes which were circulated to committee members. These forms of public administration practice accomplish certain ends, such as increased efficiency of time and communication.

Ng's work (1988) helps us to understand how people become active participants in ruling. Ng found that counsellors in an employment agency for immigrant women began to work in ways which met government and industry ends, rather than the needs of the women, when certain administrative requirements were introduced. Despite their good intentions, the counsellors took for granted the administrative demands made of their agency, yet as Ng notes their work became re-oriented by these demands to different priorities. The Board negotiating team took for granted as legitimate the Ministry's ways of working, despite their mounting frustration at the stalled negotiations. That is, they failed to see that they and the Ministry were engaged in different kinds of work.

The "troubles" experienced by the Regional Health Board arose as the two sets of players in this drama worked from ideologically incompatible frameworks. A community development and citizen participation approach informed the Board's local organizing work. The Ministry of Health continued their routine public administration practices, albeit within a "reorganized" Ministry. I argue that the Ministry's ideas and practices of "participation" can best be described as "consultation", where the ideas and concerns of people are sought, yet where the control remains with the sponsoring body. Added to the explicit differences in plans and priorities were a set of work practices that each side used and which were never discussed. Buried in these different practices were their contrasting views about, for example, citizen participation and community control.

As I shall show in the next chapter, the Board and Ministry each developed their own ideas and documents in regards to "co-management", an interim arrangement to the transfer of mental health

services and programs to the region. The Board's ideas and plans for co-management arose out of its local community development process, while the Ministry's co-management plans arose out of extra-local relevancies.

# CHAPTER FIVE

# THE SOCIAL ORGANIZATION OF THE TROUBLES WITH CO-MANAGEMENT

The attempt by the Regional Board to reach an agreement with the Ministry about how to manage the region's mental health services, brought matters to a head. The "troubles" which the members of the transfer negotiating team encountered, clarified, for the Board, IMHRAC and the TTSC, that it would not be possible to achieve their vision of regional mental health care. Although both the Board and the Ministry voiced commitment to the idea of "citizen participation", they had developed different, contentious practices. Again, through the "troubles" experienced by staff and trustees of the Regional Health Board as they attempted to negotiate the "co-management" agreement, we see the competing ideas and practices of the Board and the Ministry. The Board discontinued negotiations once they recognized, absolutely, that the Ministry insisted on retaining the power to determine what constituted adequate planning.

## Troubles Arise over Co-Management

Between August, 1993 and January, 1994 the Regional Health Board staff and trustees continued its community-based process of mental health consultation and planning, and negotiated with the major organizations which would be impacted by the transfer of authority for mental health services. In preparation for transfer, the Board and the major provider organizations developed draft contracts setting out their contractual relationships, in regards to regional mental health services and programs. The TTSC negotiating team continued to meet with their Ministry of Health contact. A conflict was developing over the management of mental health and alcohol and drug regional services in the region. The members of the Transition Team Steering Committee recognized that the Ministry of Health would not be transferring to the Board the entire regional funding envelope for mental health services and programs in the near-future. They saw that they would have to develop some interim arrangements, especially about management. One of the alternate ways of moving the transfer process forward that was suggested was

for interim management through a "co-management" agreement. The following excerpts reflect a Regional Health Board trustee's perspective of the innovative plans for "co-management", that is, for an arrangement whereby the Ministry and the Regional Board had joint management responsibility for regional mental health services and programs.

Trustee: "The management of mental health by the Board was always meant to be a temporary arrangement. The Board did not see itself as a direct employer, at that point, as far as delivery was concerned."

PL: "How did the idea of "co-management' arise?"

Trustee: "I guess that the simplest way to describe that is to say that it was a compromise position, once the Transition Team realized that there were many hurdles standing in the way of a transfer of provincial services to the Board. It seemed that this was the only way this thing was going to advance, because the Ministry wasn't ready or able to move everything over to the Board, in the final analysis. The only way to do this was through co-management" (Interview with a Board trustee, June, 1995).

The members of the TTSC negotiating team recognized that an agreement to co-manage, while a step in the right direction, would not be sufficient in itself to ensure local mental health service reform. To do that, the Board would require control of local mental health funding, as well as the authority (through their own manager) to make the needed changes.

Hence, in January of 1994 the TTSC negotiating team recommended to Ministry of Health officials that a Mental Health manager be hired by the Regional Health Board, as part of the co-management agreement, to assume interim responsibility for direct service operations. A Board trustee had this to say about the need for a Mental Health manager as part of the co-management agreement.

"We'd gone in there [to the transfer negotiations with the Ministry of Health officials) firm in the belief that [mental health] services would be transferred to the authority of the Board. Therefore the Board would be accountable and responsible, and to do that, you had to have your own person" (Interview with Board trustee, June, 1995).

This need for a manager accountable to the Board wasn't just a paranoia. The Board, its subcommittees and the mental health community recognized that the Ministry people had a different way of doing things, and that they were not all that supportive of the kind of citizen participation that had been developed.

The Board negotiating team and the Ministry of Health official spent a great deal of time discussing the "co-management" agreement and the manager position. Throughout the negotiation process, draft documents regarding co-management, prepared by the Regional Health Board, were used as the basis of discussions. The Board negotiating team was clear about what they wanted. In order to achieve any semblance of community control, they preferred to negotiate from the basis of their own documents. According to a Regional Health Board staff, the Ministry of Health official, in the Fall of 1994, prepared a separate set of draft documents regarding co-management, which reflected his ministerial perspective. These documents, prepared separately, offer a clear view of the differences in positions underlying the two sides of the negotiations. The Board's documents indicate that the mental health manager is to be responsible to the Board, while the Ministry's documents indicate that the mental health manager is to be "on loan" to the Board, from either the Ministry or another health service providing organization. In the remainder of this chapter, I will examine the ideas and practices of the Regional Health Board and the Ministry of Health in regards to co-management and the hiring of an interim manager, using the two sets of documents described above.

## The Board Documents its Position on Co-Management

From the perspective of the Board, it was necessary for the interim co-manager ("Team Coordinator") to be responsible to the Board, in order to have the authority to make the necessary changes that were identified through the earlier consultative processes. A principle was at stake here. If "New Directions" was **really** about promoting citizen participation, then the decisions and plans made through the Board's citizen development process should prevail.

Of particular importance was the issue of accountability. In order for the interim manager to be able to effect the changes identified through the earlier mental health consultation process, he or she would have to be responsible to the Board.

"Well, um, it seemed illogical to assume that the Board would take on these responsibilities without having some managerial authority through which the management could be accountable to the Board.

There was insistence, backed up by the Board, that that position be a Board position. That is, that the individual and the position be accountable to the Board" (Interview with Board trustee, June, 1995).

Members of the mental health community agreed, noting that for them it was particularly important for the team coordinator position to be autonomous of the Ministry. The already existing problems within the mental health system had left members of the mental health community mistrustful of the Ministry of Health. This was not simply a whim, but arose from the feeling that the Ministry of Health had, for some time, mis-managed mental health services.

"The feeling in the mental health community, as represented through IMHRAC and the TTSC, was that the position could not be filled by a Ministry employee because the constituency which had a lot of questions about the Ministry's management of mental health would see it as a capitulation to the Ministry" (Interview with Board trustee, June, 1995).

As I shall show, the TTSC negotiating team reflected these ideas in the various documents which they prepared to form the basis of their negotiations with Ministry of Health officials (Interview with a Board staff member, January, 1995).

The Regional Health Board documents stated that the "team coordinator of mental health and alcohol and drug services" would be responsible to the Board. The Board's documents explain the role and accountability of the "team coordinator" as,

"a member of the Operations Coordination Team and under the general direction of the Regional Health Board's Executive Coordinator, and Board of Trustees, the Team Coordinator (of Mental Health and Alcohol and Drug Services) is responsible for advising the Trustees of MH [Mental Health] and ADS [Alcohol and Drug Services] operations and for co-management of Ministry of Health Mental Health and Alcohol and Drug Services" (Regional Health Board, Draft Job Posting, December, 1994).

This description lays out the relationship of the team coordinator vis-a-vis Regional Health Board staff and trustees. The team coordinator would be accountable within the Regional Health Board structure, to the Board's executive coordinator and trustees, and would hold a position within the operations coordination team, the team responsible for the coordination of community development and planning within the region.

In the preceding quote, the Regional Health Board and the Ministry of Health are described as having a functional "co-management" relationship, the details of which are spelled out from the Board's perspective, in a document entitled "Parameters of a Co-Management Agreement between the [Regional] Health Board and the Ministry of Health respecting Mental Health and Alcohol and Drug Services in the Region". In this document, the Board's Mental Health/Alcohol and Drug Services Team Coordinator, together with the Ministry of Health's Alcohol and Drug Services Area Manager and the Mental Health Area Director would form a Mental Health/Alcohol and Drug Services co-management team, coordinated by the Board's Team Coordinator.

> "The MH/ADS Team Coordinator operates within the parameters of a co-management agreement between the MOH and RHB. The agreement establishes the functional responsibilities of each partner. The MH/ADS Team Coordinator is expected to work with existing managers in the MH and ADS system to ensure that the above listed functions are carried out in a way that is consistent with the operating principles and guidelines of the RHB" (Regional Health Board, Draft Job Posting, December, 1994).

Once again, the TTSC negotiating team was attempting to clarify their ideas as to the relationship that the team coordinator would have with ministerial counterparts. The two existing managers in the Ministry would remain ministerial employees, with the new team coordinator responsible to the Board for ensuring that Regional Health Board planning priorities were operationalized.

In the Board's document outlining the MH/ADS team coordinator position, there is also reference to an "open" hiring process. The TTSC negotiating team position regarding the hiring itself was intended to be compatible with their already existing community development ideas and practices. For the TTSC negotiating team, the hiring process was not about shuffling people from one organization or position to another. Rather, the process was designed to be open to any and all interested candidates, in a way which involved mental health system stakeholders in the decision-making. Hence, a diverse selection team was outlined. Members of Board subcommittees such as the human resource committee, IMHRAC and the TTSC team, as well as Board staff were included in the hiring process. However, others not traditionally included in managerial hiring processes were also included in the hiring team, such as a psychiatrist, frontline staff from both the mental health system as well as the alcohol and drug system, and a mental

health consumer (Regional Health Board, Draft Job Posting, December, 1994, p. 3).

With all of the time and consideration which had gone into the Board's position regarding co-management and the team coordinator, it was particularly troubling for the negotiating team to realize that the Ministry had different ideas and expectations which were at odds with decisions made through citizen participation. This became glaringly evident, when, in December of 1994, the Board's contact in the Ministry indicated to the negotiating team that the Ministry insisted that the team coordinator position be filled through the Ministry of Health's newly developed "loan staff" policy.

"The Ministry of Health is saying that they will contribute a person (their manager) who reports to them and who is employed by them, but who has only a functional relationship with the Board" (Interview with a Regional Health Board staff, December, 1994).

This would mean that the team coordinator would remain an employee of their home organization (i.e. the Ministry of Health or another health service-providing organization) and would not be employed by the Board. This decision by the Ministry was experienced as a betrayal by the members of the negotiating team and the Regional Health Board. My analysis offers another reading of the situation that includes the state's responsibility for governance that I see as a key feature of what is happening here. As I will show in the next section, the Ministry's decisions in regards to co-management and the team coordinator are examples of the state's extra-local control affecting what the Regional Health Board understood and undertook as local planning.

## The Ministry's Position on Co-Management

*"Issues are formulated because they are administratively relevant, not because they are significant first in the experience of those who live them" (Smith, 1990, p. 15).*

The Ministry of Health official involved with the transfer negotiations had developed a document, "Mental Health/ADP Framework for Co-Management" to stand as the definitive document guiding the transfer process. In this document, the team coordinator position is linked with the ministerial policy on transitional staff support for regional health boards ("Recruiting transition staff

resources", Ministry of Health, December, 1994). This transitional support policy was developed within the Ministry as part of its planning for "the utilization of macro regional office staff" ("Recruiting transition staff resources", Ministry of Health, December, 1994, p. 3). In other words, this policy set out how staff who had up until then been central office staff would be "regionalized" as part of "New Directions". Of particular concern was that "restructuring be accomplished within existing financial resources" ("Transitional staff resources for boards and councils", Ministry of Health, 1994, p. 3). The ministry's document outlining the team coordinator position states,

"The Team Coordinator can be recruited immediately using the principles described in the letter dated December 12, 1994 from John Greschner and Thea Vakil to Boards outlining the Ministry policy for recruiting transition staff resources. **Anyone from the Health Sector in the Region**, including Ministry headquarters staff, may give an expression of interest; the Board will go through a selection process and **invite that individual's organization to loan them to the Board**. The individual would carry out the duties described in the Team Coordinator job description, but **would remain an employee of their current organization**. The organization would be responsible for their salary/benefits, etcetera" (Ministry of Health, Proposal Mental Health/ADP Framework for Co-Management, December, 1994, bold face my emphasis).

The implications of the Ministry of Health's concept of team coordinator versus the Board's, is that through the "loan" or "transition staff resource" policy of the Ministry, the individual would not be a Board employee. Rather, the person would remain an employee of their current organization, merely loaned temporarily to the Board. Although this person could technically come from any health sector organization in the region, it would be unlikely that any organization other than the Ministry of Health would have the human resources necessary to relinquish a person for this position. As well, an open recruitment process would not be possible within the "loan" policy framework, as the selection would be limited to certain employees of the Ministry or other organizations.

As well, the Ministry of Health document gives the impression that the team coordinator would only be one of three managers each with the same level of authority. The Ministry document describes the relationship between the two managers and the team coordinator in the following terms,

"a three person management team comprising the Coordinator of Mental Health/Addiction Services, Regional Director of Mental Health and Area Manager Addiction Services" (Ministry of Health, "Proposal

mental health/ADP framework for co-management", 1994, p. 5).

In the Ministry's version, the team coordinator is part of a three person team, rather than coordinator of the team.

The need for the Ministry of Health to accomplish co-management and the hiring of a team coordinator within "existing financial resources" had very little to do with the Ministry's relationship specifically with the Regional Health Board. Board staff and trustees recognized that the Ministry had alternative courses of action available to them. The Board staff quoted below outlines one alternative which the Ministry might have considered, in order to move the process forward,

"The Ministry could transfer mental health funding money, and the Board could decide to hire someone out of that money" (Interview with a Regional Health Board staff member, December, 1995).

The Ministry of Health was not prepared to relinquish control over the region's mental health funding envelope, citing other considerations, such as their need to "set up a relationship between the Ministry and the [Regional] Health Board that is compatible with other regional boards" (Ministry of Health, "Proposal mental health/ADP framework for co-management", 1994, p. 1). The Ministry clearly did not want to set any precedents in their negotiations with this Regional Health Board; precedents which they might have to honor or consider in subsequent "New Directions" negotiations with other Boards around the province.

One consideration which the Ministry of Health cited as a barrier to immediate transfer of funds was the process of negotiations which the Ministry and various unions had undertaken. In their co-management document, the Ministry outlined as one of its goals "[to] honour Union/Management agreements and current negotiations pertaining to Bill 48" (1994, p. 1). Embedded within the Ministry's proposal regarding the co-management position was the complex relationship between the Ministry and provincial labour unions, as a result of the changes envisioned within "New Directions".

The "New Directions" process was presenting unique difficulties between the Ministry of Health and the labour unions. Jobs were at issue, as many unionized positions within the Ministry of Health were scheduled to be regionalized as "New Directions" moved programs to the communities. Questions were

being raised as to which unions would have jurisdiction over workers who would be moving to community or regional positions. BCGEU (B.C. Government Employees Union) had jurisdiction over central government employees, who, when transferred to regional boards, would no longer be within the mandate of the BCGEU. Rather, they might be within the jurisdiction of another union, such as the BCNU (B.C. Nurses' Union) or HEU (Health Employees' Union). A Board staff member described the union complexities this way.

"Mental health is unique, in that it has direct Ministry of Health employees providing service. As well, there are Ministry of Health employees who work in Mental Health Services in the Ministry. There are issues of successorship rights, as the other unions such as BCNU, HSA, HEU, PNU become involved, in addition to BCGEU" (Interview with a Board staff member, December, 1994).

The complex nature of the changes planned under "New Directions" had led to the development of a Labour Commission, chaired by Commissioner Dorsey, to identify and make recommendations regarding the aforementioned union jurisdictional boundaries. The Labour Commission was not scheduled for completion until July, 1995. In the meantime, the Ministry of Health had apparently made agreements with the unions that affected the mental health negotiations, leading a senior ministry official to write,

"Once the recommendations from the Dorsey Commission are finalized, and health and management plans are approved, the transfer of authority, programs and staff to the regions will begin ("Employees Online", Ministry of Health, June 2, 1995).

Given the explicit expression of differences that had been until then only implicit, the community-based team reluctantly had to recognize that the two versions of the management and organization of regional mental health services and programs were not congruent. The Regional Health Board's ideas regarding co-management arose out of their local process of community development, and their inherent emphasis on citizen participation. The Ministry's ideas about co-management, on the other hand, arose out of extra-local considerations which had very little to do with reforming and re-organizing regional mental health services in ways seen as necessary by people within the community. The Ministry of Health's considerations were those related to broader concerns about governance.

Crisis

The disparate views were finally reaching a place where one would prevail. The Ministry had the power to say yes or no to the negotiating team's request for a team coordinator who would be autonomous of the Ministry, instead responsible to the Regional Health Board. The negotiating team was getting the message that the Ministry intended to treat the Board as supplicant, rather than "partner" as outlined in "New Directions".

"I believe that our Ministry contact was trying [to reach a resolution throughout the negotiation process]. However, he did not let us forget that until such a time that the Ministry and the Deputy and the Minister were convinced that the Regional Health Board was capable of undertaking this [transfer of mental health and addiction services], that it just was not going to go" (Interview with a Regional Health Board trustee, June, 1995).

When the Ministry contact announced to the TTSC negotiating committee that the Ministry of Health was not prepared to agree to a co-management team coordinator employed by the Regional Health Board and autonomous of the Ministry, the members of the TTSC recognized absolutely that the Ministry of Health intended to exercise its authority and control over them. Reluctantly, the Transition Team Steering Committee and the Interim Mental Health Regional Advisory Committee recommended to the Regional Health Board that transfer be effectively placed "on hold".

"It was a hard decision to make, you know. Those two committees [IMHRAC and the TTSC] had developed a good rapport. There was a lot of sharing, a lot of good ideas, a lot of positive energy. To have to go in and say that this [the incompatible versions regarding co-management and the team coordinator position] was a "no go", was pretty tough. It certainly distressed many people. I recall the Transition team being very discouraged and distressed by it. IMHRAC also had the same sort of reaction, particularly users themselves and their advocates, or some of the folk that came from the non-governmental agencies. They were very discouraged" (Interview with a Regional Health Board trustee, June, 1995).

The members of the Regional Health Board agreed with the recommendation of the Transition Team Steering Committee and the Interim Mental Health Regional Advisory Committee to discontinue further negotiations with the Ministry of Health over the transfer of mental health and alcohol and drug programs.

"The Board recognized that it didn't make sense to continue at this point. They acknowledged that they have advisory committees for a reason, and that it makes sense to support the ideas and recommendations of such a committee. IMHRAC said "No, don't continue", as they could see that they would not get the outcome they wanted. It was being organized by the Ministry of Health as yet another branch office of the Ministry. The Transition Team also recognized that they would not get a satisfactory outcome" (Interview with a Regional Health Board staff member, January, 1995).

The Regional Health Board communicated to the Ministry of Health that they would no longer continue negotiating for transfer of mental health and alcohol and drug programs. In an open letter to the Minister of Health (Paul Ramsey), the Board Chairperson stated,

"I am writing to inform you that the Board of Trustees has decided to suspend current discussions with the Ministry of Health regarding a co-management agreement for Mental Health and Alcohol and Drug Services.....Regrettably the past fourteen months of discussion with the ministry has not resulted in achieving the common goal envisioned by the participating partners in this process. Our latest discussions with ministry officials clearly indicated that while the ministry is not ready or able to transfer staff, funding or authority at this time, it is willing to negotiate a co-management agreement.....This proposal is significantly different than what was originally developed with extensive community and provider participation and support for it would place upon the Regional Health Board responsibility and accountability with no real authority. Our mental health community...has expressed to us their frustration and lack of confidence in not being able to achieve a service and support system which will meet the real needs of the community. Both our community-based Mental Health Advisory Committee and our Transition Team Steering Committee have strongly advised the Board against participating further with this process until such time as the government is prepared to transfer the appropriate level of authority commensurate with the level of responsibility expected. It is their view that the Board's lack of authority would confuse both the consumers and service providers in the mental health field and create disruptions in service. As well, local decision-making, a cornerstone of New Directions, would not be realized.

It is clear that the approach originally envisaged a year and a half ago, whereby the Board would assume transitional management for these ministry programs, is no longer the most appropriate approach, given today's environment" (Regional Health Board, Open Letter to Honourable Paul Ramsey, Minister of Health, February 3, 1995).

I contend that this situation shows the different versions of co-management held by the Regional Health Board and the Ministry of Health. The Board's transfer negotiating team had developed and organized draft documents to reflect what they understood to be community priorities and issues regarding "co-management". As a practice, this meant that the negotiating team continually consulted IMHRAC and the TTSC, and incorporated their ideas and concerns into the development of documents.

The Ministry of Health official's ideas regarding co-management, on the other hand, arose out extra-local relevancies which concerned the government. These extra-local controls, while having very little to do with regional mental health reform, became embedded in the Ministry of Health's documents

and stood as the version of co-management which the Ministry was willing to negotiate. Once again, the Regional Health Board and the Ministry of Health had different and incompatible ideas and practices.

In this chapter, I have traced the action of the Transition Team Steering Committee as, under the aegis of the Regional Health Board, they attempted to plan for a transfer of mental health services, in ways which valued public participation and community development. The plans and practices which emerged from and were compatible with public participation, were not compatible with the plans and practices of the Ministry of Health. And so, the Regional Health Board reached a decision to discontinue negotiation of the transfer of responsibility for regional mental health services and programs.

In this way, the Ministry of Health rejected the community's mental health plan, as they continued their routine public administration practices and developed their own version of regional mental health services, all the while holding the power to determine adequate planning on the part of the Board. While some members of the Board and the negotiating team felt that the mental health transfer process was intentionally subverted by ministry "bureaucrats", I contend that officials in the Ministry of Health inadvertently subverted the process through continuing to work and think in ways sanctioned within the Ministry. The Ministry's plans and practices, while compatible with their own priorities and problems of governance and public administration practices, were not congruent with the Regional Health Board and mental health community's plans and practices. In the final analysis, the Ministry retains the mandate to govern. It exercised this power by making definitive conditions, in this case, for how a coordinator was to be selected and hired.

# CHAPTER SIX

# CONCLUSION

This research is about an innovative health policy and its implementation as researchable practice. "New Directions" was touted as a distinctive health policy, one which was to involve citizens in health policy planning and implementation. I initiated this research in order to gain an understanding about citizen participation and community development as strategies in the implementation of the "New Directions" policy. My previous front-line practice in health care had provided me with insights into the organizational and systemic barriers which can impact the process of community development, and the resulting challenges to the traditional organizational exercise of power.

In the conceptual framework for this study, I showed that much of the literature about policy and its implementation is devoid of human agency. Policy literature missed what for me is the crucial question, "How exactly did this happen?". This is apparently also a perplexing problem for public administrators and policy makers, who frequently see otherwise good policies "failing" owing to resistance or misunderstanding at the frontline levels of an agency whose everyday activities either puts the policy into practice or distorts it. In my research I wanted to look at this new form of health policy and its implementation in a different way than the implementation literature typically does; as a set of everyday practices. This led me to design and undertake this study using institutional ethnography. Through this methodology, and beginning with the experiences and activities of the Regional Health Board staff and trustees, it became possible to explicate the extralocal relations which shaped their troubled and eventually futile experiences of attempting to transfer authority for mental health services and programs from the Ministry of Health to the region. Through institutional ethnography, I was able to explore the questions of this study, namely, "[t]hrough what opportunities (activities, decisions) can/does the Regional Board establish regional priorities, objectives, and plans in order to develop a regionally-defined character for health care? How does this policy get put into practice through everyday activites of real people?"

In the province of British Columbia, citizen participation is being called upon by government in

the reform and reorganization of health care. For government, the need to reorganize has arisen out of fiscal challenges. As a result, there is a need for health care to be reorganized so as to achieve various economies in use of staff and other resources and to absorb increasing demand in ways that are no more costly than the current system. In this study, I found that citizen participation, originating in this way, takes a different direction than the community-held view of participation which arises out of a community development approach. The "troubles" that citizens experienced as they tried to "participate" were not created (as some Board members thought) by Ministry officials' obstructive behaviours. Rather, the approach to implementing policy through citizen participation taken by Ministry officials, on the one hand, and citizens working in conjunction with Board trustees and staff, on the other hand, were dissimilar and incongruent. Each group failed to see that they and their counterparts were both working according to a set of practices that was congruent with their different approaches. It appears that the new managerial technology of "participation" by citizens disrupts conventional public administration practice, but does not alter the exercise of centralized power, even in the more decentralized state organization that was being put in place through this policy and related Ministry practices.

In the conceptual framework for this study, I identified a number of contradictions inherent in the concepts underpinning the implementation of public policy generally, and "New Directions" specifically. Among the contradictions are the notions of citizen participation and community development as inherently "good", juxtaposed with decentralization or regionalization as necessarily weakening the state; of power and empowerment of ordinary citizens versus the idea of government control. In the remainder of this conclusion, I will re-explore these concepts and contradictions, based on my learning from this research.

In the literature there is a taken-for-granted theme of "goodness" surrounding the concepts participation and community development, with assumed attributes ranging from "empowerment" to various forms of "control". In the documents underpinning "New Directions", citizen participation is assumed to be "good", not only for individuals, but also for communities, regions, and even for government. Central to this taken for granted "goodness" is the notion that citizen participation, de facto,

improves or increases opportunities for democracy or democratic expression.

Throughout this research, I found that people both within the Board and the Ministry were highly committed to the idea of participation, taking for granted that participation is inherently "good". Participation was identified by both Ministry officials and Board trustees and staff as a desirable strategy for the implementation of "New Directions", assumed to provide opportunities for involvement in democratic process. This central feature of "New Directions", citizen participation, remained unquestioned and was assumed to be beneficial.

The literature itself is inconsistent in this regard. Citizen "participation", identified as essential to regionalization in "New Directions" is assumed to improve democracy. Yet it runs counter to the notion of democracy served by a strong central government with public administration as a principal feature. In this research, I found that Ministry of Health officials were working hard in ways sanctioned within their modus operandi, public administration. Theirs is a time-honoured approach to maintaining a liberal democracy, inflected by contemporary thinking about involving citizens.

At the same time, Board trustees and staff were also working hard in ways compatible with their overall community development philosophy to empower citizens. As became evident, each group had very different goals and practices and the two approaches were often incompatible with each other. In fact, each "side" failed at important moments to see the other's work as a valuable contribution and eventually it came to an impasse that ended the participatory effort. The transfer of mental health services from the Ministry to the region did not happen. The struggle around the Board's and Ministry's different goals and practices was never taken up analytically, and the contradictions inherent within the idea of citizen participation in implementation as central to regionalization and decentralization were neither identified nor addressed by those involved.

As I noted earlier, community development, like citizen participation, is assumed in much of the literature to be "good" and to lead to "empowerment". In this study's conceptual framework, I included authors such as Dominelli (1990) who queries this inherent "goodness", instead wondering "who" it is that community development is good for, and Dixon (1989) who wonders whether "empowerment" can be

a result of government-originated community development. Once again, an inconsistency is evident in the concepts underpinning the "New Directions" policy reform. The community members and Regional Health Board staff linked participation with improved democratic decision-making. They identified community development, with its "empowerment" focus as a strategy for increasing citizen participation. But, as I have pointed out in Chapter Four, governing or "ruling" is the responsibility of government. In order for "empowerment" of citizens to occur, something would have to give. The way that government works or does its ruling would have to change in some way in order to shift any state responsibilities to citizens' hands. This would have consequences for the form of government that exists in Canada, and which is formulated through public administration principles and practices to support liberal democracy (Kernaghan and Siegel, 1991). We might want to ask if a decentralized or regionalized approach to health care restructuring that actually empowers people would threaten the democratic state.

Through my research, I discovered that the "New Directions" policy took a back seat to the established ways of governing, built around particular ideas about democracy, and practiced as public administration. I found that the "relations of ruling" work in such a way that local interests are subordinated to the "public good" as public officials define it. This became evident as the need of the government to honour particular union agreements took precedent over the region's mental health planning process, and as a result, led to the Ministry of Health making certain demands of the Board and refusing others. Although the Ministry of Health did make some changes such as the reorganization of its managerial structure, from the community development perspective these changes appeared more cosmetic in nature than anything else. There were no actual changes which would lead to a shift in control over the operation of mental health services. It remains questionable, then, as to whether democracy can be forwarded through this new policy emphasis on citizen participation.

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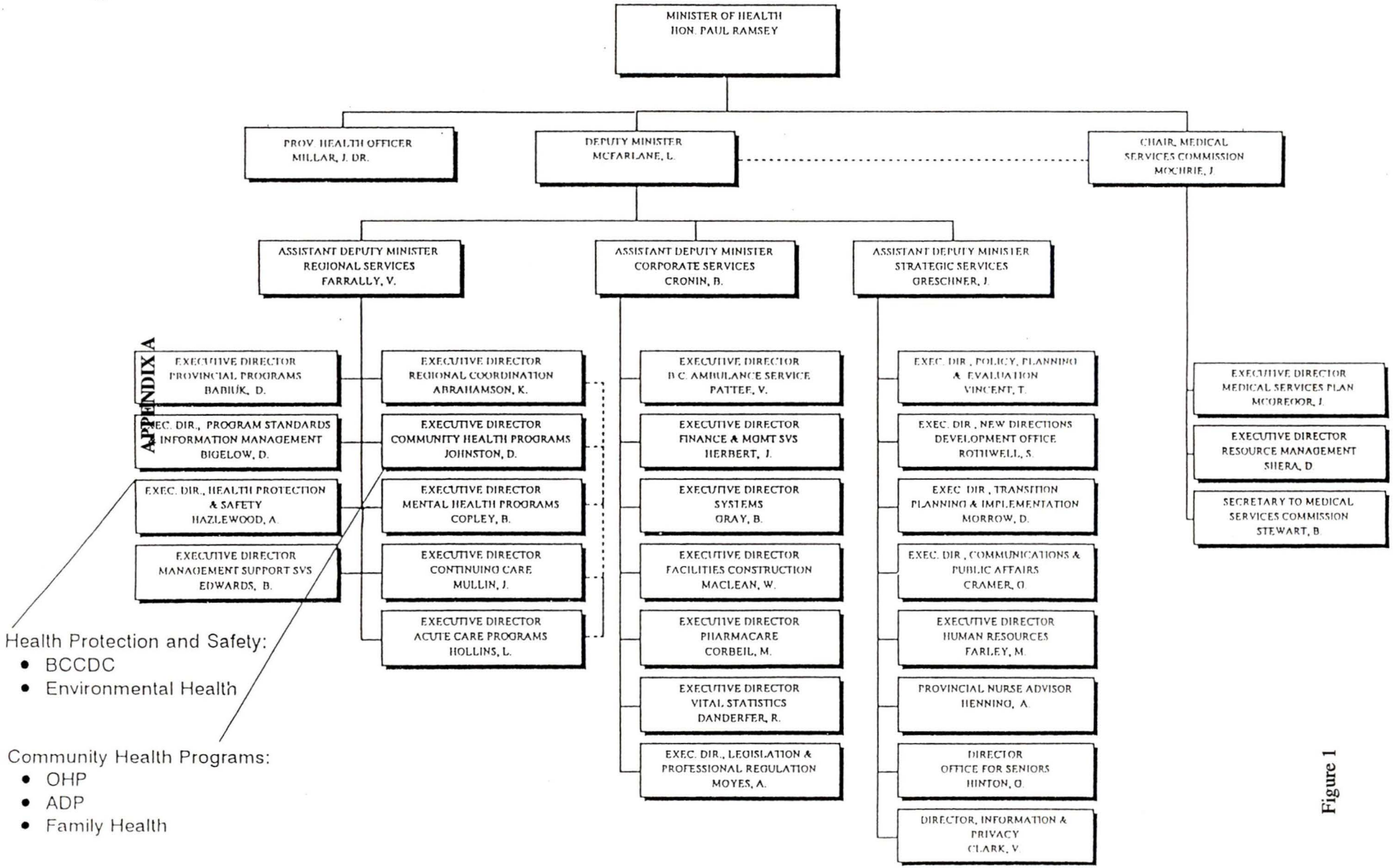
# ORGANIZATION CHART



NOVEMBER 23, 1993



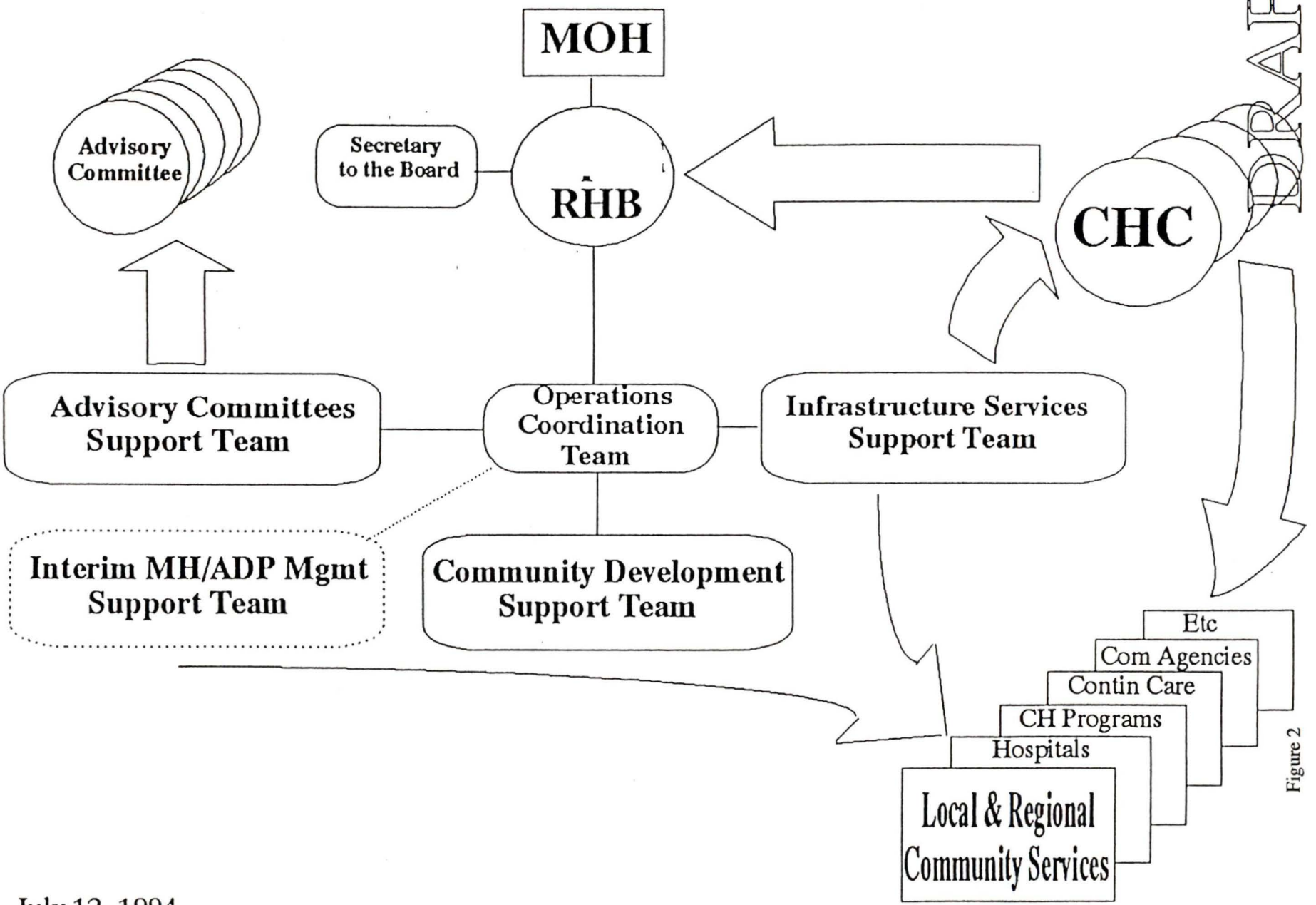

APPENDIX A

Health Protection and Safety:
- BCCDC
- Environmental Health

Community Health Programs:
- OHP
- ADP
- Family Health

Figure 1

# Staff Organization Overview




DRAFT

Figure 2

## Administrative Organizational Charts

# Organizational Overview

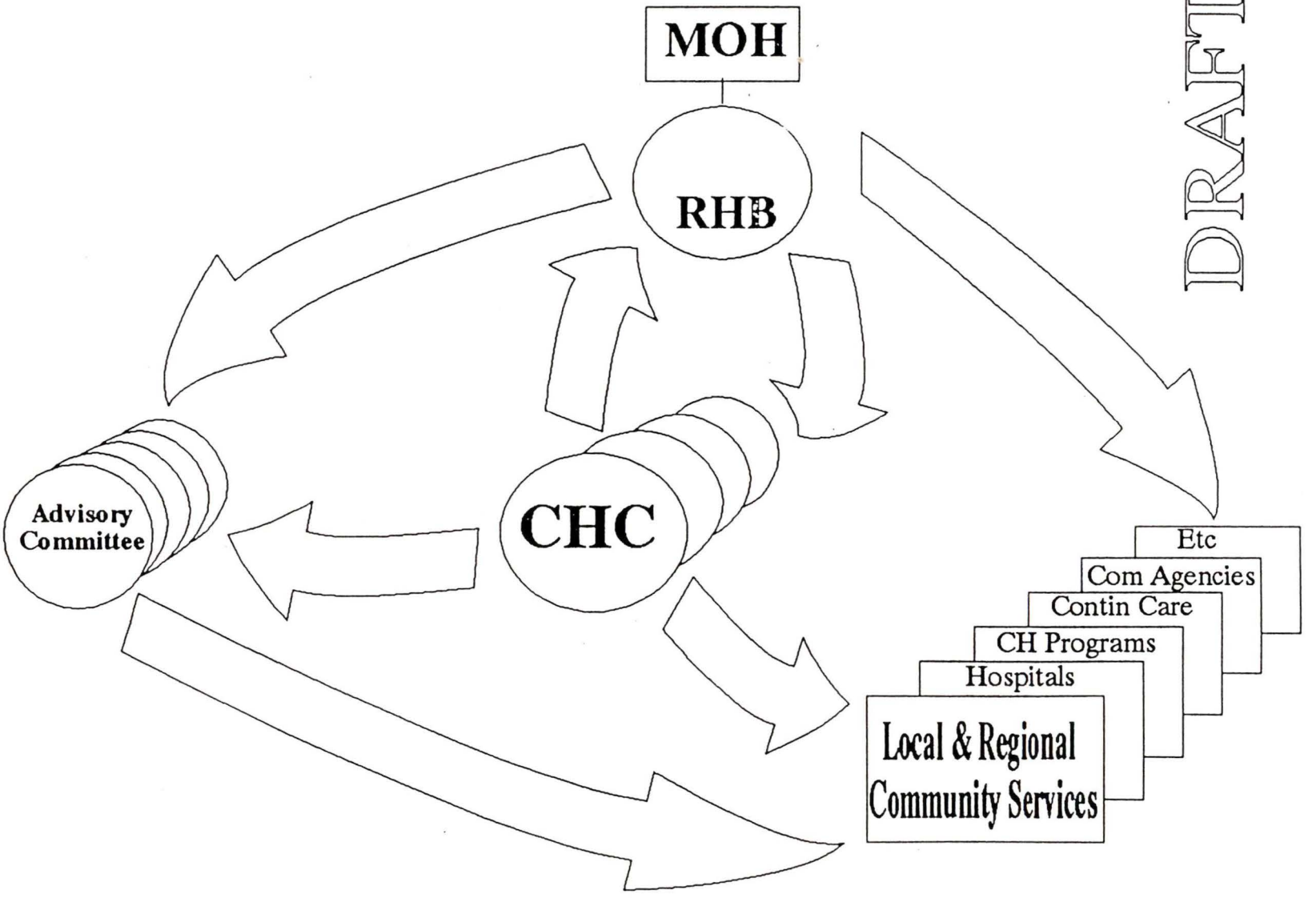



Figure 3

# VITA

Surname: Larson Given names: Patricia Laura

Place of birth: Shaunavon, Saskatchewan, Canada

**Educational Institutions Attended:**

| | |
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**Degrees Awarded**:

| | | |
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**Honours and Awards:**

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