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**ENABLING EMPOWERMENT OR MANAGING MEDICAL CASES?
OCCUPATIONAL THERAPY'S MENTAL HEALTH WORK**

By

Elizabeth A. Townsend

**Submitted in partial fulfillment of the requirements
for the Degree of Doctor of Philosophy**

at

**Dalhousie University
Halifax, Nova Scotia
May, 1994**

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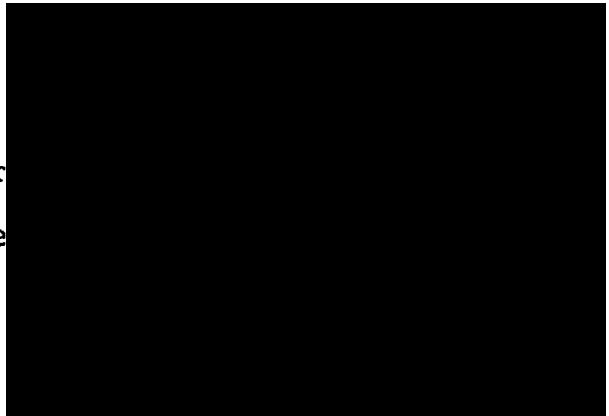
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DEDICATION

To my mother 'Betty' Townsend (Alice Marion Boyd) whose 'whim of iron' and commitment to fairness inspired a thesis on empowerment long before this study was even conceived.

To my father 'Fred' Townsend (John Frederick) whose example of courage and persistence taught me how to pursue a vision.

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TABLE OF CONTENTS

TABLE OF CONTENTS	v
LIST OF FIGURES AND TABLES	x
ABSTRACT	xi
'OCCUPATION' DEFINITIONS	xii
CODE NAMES OF OCCUPATIONAL THERAPISTS AND SITES	xv
ACKNOWLEDGEMENTS	xvi
CHAPTER 1 INTRODUCTION	1
1.1 Purpose and Overview	1
1.2 What does 'Enabling Empowerment' Mean?	4
1.3 Why Enable the Empowerment of People Diagnosed with Mental Disorders?	8
1.4 Why is Occupational Therapy Concerned with 'Enabling Empowerment'? ..	9
1.5 How is Occupational Therapy Generally Known?	11
1.6 What is the Problem?	14
1.7 What is Known about 'Tensions' in Occupational Therapy?	15
1.8 What is the Significance of the Study?	21
1.8 Looking Ahead	22
CHAPTER 2 THEORY AND METHOD	24
2.1 Introduction	24
2.2 Making the Everyday World Problematic	25
2.3 Subject Selection and the Collection of Data on Practice in the Everyday World	26
2.4 Analyzing Connections	31
2.5 Analysis of the Practice of Ideology	35
2.6 Ethics	39
2.7 Rigor	41
2.8 Generalizability	43

TABLE OF CONTENTS (cont'd)

CHAPTER 3	'PASSIFYING' ACTIVE PEOPLE	44
3.1	Introduction	44
3.2	Recognizing Persons: An Ideal Practice	45
3.3	Recognizing Patients, Cases and Clients: Occupational Therapy Literature	47
3.4	Recognizing People's 'Active Power': Glimpses of the Ideal in Occupational Therapy Practice	50
3.5	Transforming Persons into Patients and Cases: Undermining Practice	59
3.6	Summary	67
CHAPTER 4	INDIVIDUALIZING ACTION	69
4.1	Introduction	69
4.2	Connecting Individual and Social Action: An Ideal Practice	70
4.3	Emphasizing Individual over Social Action: Occupational Therapy Literature	73
4.4	Highlighting Instances of Social Action: Glimpses of the Ideal in Occupational Therapy Practice	76
4.5	Individualizing Goal Setting, Coordination and Documentation: Narrowing Practice	84
4.6	Summary	98
CHAPTER 5	CONTROLLING COLLABORATION	100
5.1	Introduction	100
5.2	Developing Collaborative Decision Making Partnerships: An Ideal Practice	101
5.3	Promoting Collaboration: Occupational Therapy Literature	103
5.4	Tentative Collaboration: Glimpses of the Ideal in Occupational Therapy Practice	105
5.5	Controlling Program Structure: Contradicting Collaboration	112
5.6	Summary	129

TABLE OF CONTENTS (cont'd)

CHAPTER 6	SIMULATING REAL LIFE	131
6.1	Introduction	131
6.2	Grounding Education in the Real World: An Ideal Practice	132
6.3	'Learning Through Doing' in Real Occupations: Occupational Therapy Literature	135
6.4	Stretching to Include Real Life Education: Glimpses of the Ideal in Occupational Therapy Practice	137
6.5	Emphasizing Simulation: Distorting the Fundamental Purpose	143
6.6	Summary	161
CHAPTER 7	RISKING LIABILITY	163
7.1	Introduction	163
7.2	Enabling Risk Taking to Produce Transformative Change: An Ideal Practice	164
7.3	Guiding Development and Adaptation: Occupational Therapy Literature	167
7.4	Enabling Risk Taking to Change Everyday Life: Glimpses of the Ideal in Occupational Therapy Practice	170
7.5	Managing Safe Risk Taking: Subduing Transformation	177
7.6	Summary	185
CHAPTER 8	PROMOTING MARGINAL INCLUSIVENESS	188
8.1	Introduction	188
8.2	Enabling Inclusiveness: An Ideal Vision of Society	189
8.3	Linking Spirituality to Inclusiveness: Occupational Therapy Literature	192
8.4	Emphasizing Worth and Community Connectedness: Glimpses of the Ideal in Occupational Therapy Practice	195
8.5	Organizing Marginal Public Spaces: Confining Practice	202
	8.5.1 Including Cases in Medical Communities	204
	8.5.2 Perpetuating Exclusionary Economic and Welfare Practices	210
8.6	Summary	222

TABLE OF CONTENTS (cont'd)

CHAPTER 9	ENABLING EMPOWERMENT OR MANAGING MEDICAL CASES? A CENTRAL TENSION	225
9.1	Introduction	225
9.2	Possibilities for Enabling Empowerment	226
9.2.1	Glimpses of an Ideal Practice	228
9.2.2	Three Arenas of Possibility	233
9.3	Constraints for Enabling Empowerment	235
9.3.1	Managing Medical Cases	237
9.3.2	Three Arenas of Constraint	243
9.4	Compromise and Resistance	246
9.4.1	'Fitting In'	246
9.4.2	Celebrating Difference	249
9.4.3	'On Balance'	251
CHAPTER 10	REFLECTING ON THE STUDY AND IMPLICATIONS FOR CHANGE	252
10.1	Introduction	252
10.2	Reflections on the Study	252
10.3	Implications for Practice: Mapping a Route Towards the Vision	256
10.3.1	Conducting Everyday Practice	259
10.3.2	Structuring Specific Programs	260
10.3.3	Organizing Professional, Institutional and Community Conditions	262
10.4	Implications for Occupational Therapy Education	266
10.4.1	Entry-Level Education	268
10.4.2	Graduate Education (Beyond Entry to the Profession)	271
10.4.3	Recruitment	272
10.4.4	Professional Continuing Education	273
10.5	Implications for Occupational Therapy Research	274
10.6	Final Comments	277

TABLE OF CONTENTS (cont'd)

APPENDICES

APPENDIX A Computer Coding: Ethnograph	278
APPENDIX B Occupational Therapy's Work Processes in Day Programs: Notes on Developing Codes for the Second Analytic Process of Institutional Ethnography	281
APPENDIX C Analytic Categories Relating Work Processes to Key Features in Literature on Enabling Empowerment	297
APPENDIX D Research Information Sheet	299
APPENDIX E Occupational Therapist Consent Form	304
APPENDIX F Occupational Therapists Interview Guide	306
APPENDIX G Instrument for Auditing Patients' Health Record	311
BIBLIOGRAPHY	315

LIST OF FIGURES AND TABLES

Figure 1	The 'Funnel' Process of Data Collection	29
Table 1 -	Occupational Therapist: Position Description (Site R)	82
Table 2 -	Goal Setting: Brenda's Weekly Goals (Site R)	90
Table 3 -	Case Coordination: Brenda's Assertiveness Goals (Site R)	91
Table 4 -	Occupational Therapist: Position Description (Site R) Case Coordinator Roles and Responsibilities	93
Table 5 -	Instrument for Auditing Patients' Health Record (Occupational Therapy) (Site R)	95
Table 6 -	Caseload and Service Time Per Case: Management Information System (MIS) (Primary Data Categories) (Site R)	96
Table 7 -	General Satisfaction Rating (Site R)	110
Table 8 -	Client Satisfaction Survey (Site N)	111
Table 9 -	People's Suggestions for Program Change (Site P)	116
Table 10 -	Policy on Confidentiality (Site P)	124
Table 11 -	Service Manual: Excerpt from "Program Description" (Site R)	125
Table 12 -	Core Curriculum: Interactional and 'Occupational' Sessions	142
Table 13 -	Categories of Risk Management Documentation (Site R)	180
Table 14 -	Work Assessment Categories (Site B)	207
Table 15 -	Enabling Empowerment: An Ideal Vision of Sharing Professional Power	227
Table 16 -	Managing Medical Cases: Processes for Managing Professional Power	236

ABSTRACT

This is a study which critically analyzes the social organization of occupational therapy's mental health work. The question addressed is: What are the possibilities and constraints for enabling the empowerment of adults who attend transitional mental health programs? Six core features identified in occupational therapy literature and the actual practice of seven occupational therapists across Atlantic Canada are contrasted against an 'ideal empowerment-oriented practice' constructed from adult education and other literature. The thesis argues that occupational therapy's mental health work is organized to produce a central tension between contradictory patterns of practice: one pattern enables people to share power; the other controls power.

Using the theory and method of institutional ethnography developed by Dorothy Smith, the analysis displays 'glimpses of possibility' for enabling people to share power. These glimpses are descriptions of actual instances of adult education in which occupational therapists educate people to become empowered in the full range of occupations which give meaning to real life. In other glimpses, occupational therapists recognize people's worth and power to act by including them as collaborators in decisions about their program goals and involvement. In some situations, occupational therapists facilitate critical reflection and real action in which people take the risks of transforming some aspects of themselves and society.

Nevertheless, these educational 'glimpses of possibility' are almost submerged by the 'constraints' of controlling power through the work of 'managing medical cases'. To some extent, people's mental difficulties and interactional difficulties in everyday situations constrain their empowerment. However, fundamental constraints lie in institutional processes designed to control power. Rather than supporting the work of enabling empowerment, these processes make occupational therapy accountable primarily for the quality and efficiency of individual case management. Control is exercised through hierarchical decision making and legal processes which protect people more than they support risk taking and change. Beyond mental health services, constraints are also organized by state legislated economic and welfare practices which perpetuate the stigmatization and marginalization of psychiatric cases.

Resolution of the central tension requires a shift from hierarchical processes of control to horizontal processes of partnership in mental health services and the economic and welfare practices of society. Such a shift would enhance the educational potential in occupational therapy's mental health work for enabling empowerment.

'OCCUPATION' DEFINITIONS

OCCUPATION

The term 'occupation', as used in occupational therapy, is drawn from the profession's historical roots in "occupational work" accomplished by "occupation aides" (Driver, 1968). Occupations are any human activity organized to fulfil a particular function (Clark, Parham, Carlson, Frank, Jackson, Pierce, Wolfe & Zemke, 1991; Meyer, 1922). Furthermore, occupations are "chunks of activity within the ongoing stream of human behaviour which are named in the lexicon of the culture" (Yerxa, Clark, Frank, Jackson, Parham, Pierce Stein & Zemke, 1990, p.5). Occupations are more than types of "work" such as "professor", "craftsperson", or "homemaker" (Canadian Communications Consulting Group, 1993). Occupations refer to what people do during the course of everyday life, including the occupations through which people look after themselves (self care), enjoy life (leisure), and contribute as full members of society (productivity) (Canadian Association of Occupational Therapists, 1994). Occupations carry particular social value and power and have become identified with 'roles' connected with gender, class, age, race, and other characteristics. The social value of occupations tends to be reflected in their economic value.

In an 'ideal' world, people have jurisdiction (choice) over patterns of occupation which have personal meaning and are valued in society. People choose occupations which achieve a meaningful balancing between mind, body and spirit. People also organize a society in which they have jurisdiction over occupations and their value in society.

Occupations provide the medium and process of occupational therapy since occupations are selected, analyzed and adapted to suit people's ability and environment (Canadian Association of Occupational Therapists, 1991; Cynkin & Robinson, 1990; Kielhofner, 1985a). One thrust

in practice is to structure environments to enhance people's participation in everyday occupations (Law, 1991). The other thrust is to facilitate individual and group achievement of meaningful patterns of occupation (Christiansen & Baum, 1991). Overall, occupational therapy's concern is with transforming people's occupations and the ways in which these are shaped by society. Occupational therapists guide individuals and groups to identify and achieve occupations and to shape local and broad social conditions to support their occupational achievement.

The language of 'occupation' has been re-emphasized in occupational therapy practice through the development of 'occupational performance' models and through the emerging basic science field described as 'occupational science' (Yerxa, 1992). Reference to occupations fell into disuse over this century in favour of 'activities' as in the phrase 'activities of daily living' or 'purposeful activities' (Hopkins & Smith, 1988). The language of occupation is regaining favour as the profession identifies occupation as its philosophic and practical core.

OCCUPATIONAL ACHIEVEMENT AND POTENTIAL

'Occupational achievement' and 'occupational potential' are occupational therapy rather than empowerment terms. Emerging in occupational therapy's informal discourse in the 1990's, occupational potential refers to people's projected potential to develop meaning in and control over life through the thoughts and actions which are organized into occupations. Projections of occupational potential are based on past and current 'occupational achievement'. Occupational achievement refers to people's actual integration of a constellation of beliefs, interests, habits and competence in the real occupations and real situations which confer meaning and control in life.

Occupational therapy has generally attended to 'individual occupational potential'. Fulfilment of individual occupational potential is a personal developmental process through which individuals produce meaning and control in everyday life. Individual occupational potential

emerges over time and experience and changes throughout life and in different contexts. The achievement of individual occupational potential is viewed by occupational therapists as enhancing people's quality of life and empowerment, and thereby contributing to social justice.

Although not clearly articulated, occupational therapy is also concerned with the development of 'community occupational potential'. The development of community occupational potential refers to the collective potential of the citizens of a cultural, geographic or other type of community to find meaning and exert control over its destiny within broader society. A community's occupational potential is being fulfilled when women and men with varying ability, culture, race and socioeconomic class have equal opportunity to develop meaning and control within that community.

CODE NAMES OF OCCUPATIONAL THERAPISTS AND SITES*

(See APPENDIX A for a list of coded data files)

References throughout the thesis to the seven study sites and the occupational therapist in each site are all coded. The seven occupational therapists and sites are:

'Bev' Site B
'Carol' Site C
'Jill' Site J
'May' Site M
'Nora' Site N
'Pat' Site P
'Rita' Site R**

All seven code names are feminine since almost 96% of occupational therapists are women (Canadian Association of Occupational Therapists, 1993a). However, using feminine code names is also an ethical procedure of ensuring anonymity by not disclosing whether or not male occupational therapists participated in the study.

Data segments extracted through ETHNOGRAPH coding are identified throughout the thesis by type of data (observation or interview), person, file code, and numbered lines. As illustration, "Interview with Rita, RINTOT06, 652-700" locates the segment as the sixth interview with the occupational therapist code named 'Rita' in Site R. The segment occupies lines 652-700 in the ETHNOGRAPH numbered file called RINTOT06.

All data segments which describe actual talk and action appear in double quotation marks ("..."). Statements or terms which are typical but not referenced quotes appear in single quotation marks ('...').

* The purposes of developing code names and locating data precisely are described in Chapter 2.6 (Ethics) and Chapter 2.7 (Rigor).

** Examples from Rita's practice are prevalent since Site R displayed individual case management (see Chapter 4) most clearly.

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INTRODUCTION

1.1 Purpose and Overview

This is a study of occupational therapy's practice of adult education. The study critically analyzes the social organization of occupational therapy's mental health work with adults. The question addressed is: What are the possibilities and constraints for enabling the empowerment of adults who attend transitional mental health programs?

The question arose because I believe that occupational therapy is an undeveloped empowerment-oriented form of education. With adults, this is a form of adult education. In my view, occupational therapy's vision and practice is to promote social justice using practical approaches which enable the empowerment of marginalized people (Townsend, 1993). Although the profession is called a 'therapy', core features of its vision and practice are educational. The title 'occupational' therapy, identifies an interest in the occupations of life (see 'OCCUPATION' DEFINITIONS', pp. xii-xiv). In other words, the practical approaches used to enable empowerment aim to educate people of all ages to develop jurisdiction (choice) over the patterns of occupation which have meaning for them and the societies in which they live. The focus is on working with people who have diverse or limited occupational potential associated with mental or physical dysfunction, aging, or social disadvantage (Canadian Association of Occupational Therapists, 1991, 1994). To do this, occupational therapy recognizes people as active decision making partners. Through experiences which people define as meaningful, people are educated to take control of their lives by engaging in real occupations which are relevant to their lives. The ethical commitment is to enable people to risk transforming disabling experiences and marginalizing conditions to become included as valued citizens in society (Kielhofner, 1992; Yerxa, 1979, 1992; Polatajko, 1992).

The problem is this. My own experience, the experience of colleagues and some occupational therapy literature suggest that occupational therapy's work is fundamentally oriented to enabling people of all ages to become empowered. But the most prevalent examples of this work, in occupational therapy and other literature, show occupational therapists managing specific physical or mental limitations associated with illness or disability. It seems that occupational therapy is characterized by 'tensions' between two different visions and types of practice. These are not the tensions of frustration or interpersonal difficulties which may arise between particular individuals in particular settings. Rather, these are socially organized¹ tensions. The social organization of occupational therapy appears to produce both possibilities and constraints for developing an empowerment-oriented educational practice.

The approach taken to study this problem has been to use literature outside occupational therapy to describe an 'ideal' practice organized to enable the empowerment of adults who use professional services. Then, from my standpoint of almost 27 years of institutional, community and academic experience as an occupational therapist, I develop an institutional ethnography² of occupational therapy's mental health work with adults who attend transitional mental health programs within provincial mental health services. To develop an institutional ethnography, I use the sociological theory and method described by Dorothy Smith (1987, 1990a, 1990b). Although institutional ethnography has developed as a feminist sociology, it is used here to analyze professional practice in which questions of gender are raised but are not the focus of investigation. The critical analysis captures 'glimpses of possibility' and 'constraints' in a spirit

¹ 'Social organization' refers to processes and practices which are actual activities in the material conditions of everyday life but which invisibly coordinate life beyond everyday experience (Smith, 1987, 1990a, 1990b).

² An 'institutional ethnography' analyzes the broad social relations of an 'institution' such as health services, education or transportation (Smith, 1987) (see also Chapter 2).

of hope (Fay, 1987; Freire, 1985; Habermas, 1973; Kuyek, 1990). Glimpses of possibility are actual processes and practices which display occupational therapists' emancipatory interest in enabling empowerment. Within the critical framework of the thesis, glimpses illustrate actual instances in which occupational therapists engage in pieces of an emancipatory practice with the people who attend transitional mental health programs. Constraints are organizational processes which undermine, distort or otherwise confine these glimpses of possibility for developing an ideal empowerment-oriented adult education practice.

The analysis examines occupational therapy literature as well as the actual practice of seven occupational therapists. Actual practice was documented during a six month field study conducted over the winter and spring of 1989 - 1990. During that time, I visited seven sites where a single occupational therapist was a member of a professional team which typically includes one or more nurses and social workers, a full or part-time psychologist, and a part-time consulting psychiatrist. Some programs included a recreation, music or other type of therapist and possibly an occupational therapy assistant. At least one site was chosen in each of the four provinces of Atlantic Canada.

The empirical account developed through this methodology holds particular significance for occupational therapy. It displays how practice with adults actually works and sets the stage for recommending how a more emancipatory practice might be developed (see Chapter 10). However, the broader significance of this analysis is for adult education, community development, political, government, religious and even business practices which have an interest in enabling people to become empowered.

In light of my association with adult mental health services since 1978, my particular interest is in enabling the empowerment of adults diagnosed with mental disorders. Since my long standing professional commitment has been to community practice, I selected transitional

mental health programs as being the most prevalent, community-oriented mental health programs which include occupational therapy in Canada (Townsend, 1988). The Atlantic Region in Canada was of primary interest since I have practised in three out of four of these provinces (all but New Brunswick) including my present position as a faculty member in the regionally-oriented and funded School of Occupational Therapy at Dalhousie University.

The rest of Chapter 1 outlines the definitions of 'power', 'empowerment' and 'enabling empowerment' which form the conceptual framework of the thesis. This chapter also describes occupational therapy's interest in enabling empowerment then indicates how occupational therapy is generally known by those outside the profession. Then, the problem of socially organized 'tensions' is described; occupational therapists' experiences and research pointing to tensions is presented; and the significance of the study is further discussed. Chapter 1 ends by looking ahead in the thesis.

1.2 What does 'Enabling Empowerment' Mean?

'Enabling' is generally described in the literature of adult education and other 'helping' fields as a variety of processes which foster self-help, mutual aid and participatory approaches which involve people in solving their own problems. Enabling tends to refer to 'helping' forms of therapy (Dunst, Trivette, Davis & Cornwell, 1988; Dunst & Trivette, 1989), facilitation of adult learning (Brookfield, 1986) or organizational procedures such as 'enabling legislation' (Young, 1990).

'Empowerment' has become a popular but trivialized word in North America. Its use appears in a variety of contexts for a variety of purposes. Powerlessness or disempowerment (loss of power) are defined as the opposite of empowerment. However, definitions of empowerment vary considerably in literature on adult and other education, health promotion, law,

management, social action, political science, psychology, and theology. Although management has taken up empowerment as an organizational strategy for enhancing productivity (Conger & Kanungo, 1988), emancipatory interests in empowerment are linked more closely with social movements promoting feminism, racial equality, gay, lesbian and bisexual rights, cultural freedom, grey power, liberation theology and, of interest here, disability rights (Simon, 1991).

In the field of health, in which occupational therapy is most clearly embedded, enabling and empowerment have become topical words particularly in literature on 'health promotion'. The work of enabling empowerment underpins Canada's conceptual framework of health promotion (Department of National Health and Welfare, 1986, 1988). Moreover, empowerment is being explicitly related to processes and measures of health (Labonte, 1989a; Wallerstein, 1992). Often enabling and empowering are defined as similar processes³ such that people have reacted with surprise to my combined phrase 'enabling empowerment'. They wonder how I connect the two words. Given problems in defining 'enabling empowerment', one approach might be to avoid use of the words altogether. Yet, I have no better words to describe work which intends to help disadvantaged people to develop personal and social conditions so that they can share power in society. Therefore, the thesis refers to 'enabling empowerment' through an 'ideal empowerment-oriented practice'.

At the outset, it is important to stress that the thesis rests on particular ideas about power in people's lives. I define power as a set of ideological processes and practices. Ideological processes and practices consist of actual activities in everyday life which also invisibly coordinate and control people's experience in the everyday world (Smith, 1987, 1990a, 1990b). In essence,

³ For instance, there have been conferences on working with people with mental handicaps entitled "Enabling and Empowering". As well, enabling and empowering have been examined as separate processes in working with children (Dunst, Trivette, Davis & Cornwell, 1988; Dunst & Trivette, 1989).

power is experienced as control over everyday actions and talk. But people's experience of power is organized by processes and practices which invisibly coordinate and control everyday life (Daudi, 1986; Fay, 1987; Habermas, 1984; Hawks, 1991; Lukes, 1974, 1986; Smith, 1990b). These processes and practices are ideological in that they categorize and incorporate the ideas, values and beliefs of a "ruling apparatus" which governs an institutional function (Smith, 1987, p.3). Therefore, ideological processes and practices are the practical "method" of power in that they organize invisible ways of controlling everyday life (Smith, 1990b, p.45).

Based on this definition of power, I view empowerment as an interconnected set of personal and social processes which transform the ways power is experienced and actually works in society (Gruber & Trickett, 1987; Pinderhughes, 1990; Smith, 1990b). Therefore, empowerment is propelled through ongoing interconnections between personal and social transformation. On the one hand, people actively transform their personal experience of powerlessness by generating new perspectives on their everyday experience (Lord & McKillop-Farlow, 1990; Mezirow, 1978). On the other hand, society is transformed by the emergence of a public ethic, policies, economic practices and laws consistent with empowerment. These public processes create the practical reality required for those without power to become full participants in the public realm (Braithwaite & Lythcott, 1989; Kilian, 1988; Pinderhughes, 1983). Moreover, empowerment is a time consuming and labour intensive process of experimentation (Kieffer, 1984). The process is energized by forward looking ideas of hope, trust and love (Adamson, 1990; Freire, 1985; Kuyek, 1990). A forward looking energy sustains people through transformative change which may threaten or overwhelm them as they take on responsibility for sharing power. The energy for empowerment is sustained through a "language of possibility and a "prophetic vision" which articulates a "philosophy of hope" (Freire, 1985, pp. xvi-xvii).

Central to these definitions is the belief that power and empowerment are not scarce commodities for which people need to compete. Rather, power, and thus empowerment, are generative resources, renewable and expanding in a synergistic community (Gilligan, 1982; Young, 1990). This generative understanding of empowerment is what makes it a forward looking process not limited to the mechanistic accomplishment of efficient action under controlled conditions (MacIntyre, 1984). In an ideal world, empowerment is available to all who are both willing to and have the opportunity to develop their potential to share power. Empowerment is a positive experience in which people realize their potential to express their true selves without being oppressed and without oppressing others (Carr and Kemmis, 1986). Ultimately, possibilities for empowerment rest on a distributive form of social justice. Empowerment requires broad social processes and practices which organize the equitable sharing of power as well as the material resources of society (Young, 1990).

Congruent with these views on power and empowerment, an ideal practice oriented to 'enabling empowerment' recognizes that people have the power to act and educates them to engage in an interconnected set of personal and social processes. This is an educational practice oriented to enabling people to become equal decision making partners in transforming powerlessness in their personal lives and society. In enabling empowerment, people who are not empowered are challenged and guided, individually and collectively, through the risks of incorporating critical reflection with real action to transform themselves and society. Moreover, the work of enabling empowerment fosters development of a public ethic and the institutional, economic, welfare and professional practices required to foster human growth within an inclusive society. In essence, enabling empowerment is the educational work of building a society which actually shares power and resources equally and celebrates the diversity of people's characteristics and practical contributions to that society. Therefore, an ideal practice enabling empowerment

resounds with a broad but pragmatic vision of the practical possibilities for developing social justice⁴.

1.3 Why Enable the Empowerment of People Diagnosed with Mental Disorders?

People with disabilities have historically been amongst the most disempowered people in society (DeJong, 1979). They have tended to be either sanctified as special or segregated out of fear, disgust or their own inability to fit within mainstream society (Zola, 1975). Disability is a general term referring to limited ability. But the term is used to describe a diverse range of problems associated with physical, emotional, cognitive/learning, sensory or other biological characteristics which place some people outside what are considered normal expectations for performance in everyday life (Wolfensberger, 1972).

Much attention has been given since the 1970's to people defined as physically disabled, particularly public figures such as Rick Hansen, who have been able to enter many parts of regular society with the help of wheelchairs and architectural adaptations to buildings, streets, transportation and so on. People with physical disabilities have begun their empowerment through their own personal transformation interacting with the development of political, economic and legal conditions which support some degree of transformative change. There is increasing affirmative support for them to find housing, employment, sports and other opportunities. Their transformation has been helped enormously by technology and by their development of Independent Living Centres and self-help groups (Coalition of Provincial Organizations of the

⁴ This definition of 'enabling empowerment' has emerged through the analytic approach of the thesis. It incorporates views on enabling and empowerment in various fields of literature and is transcendent in that it *does not fully exist in reality*. Furthermore, the thesis displays institutional constraints which suggest that the potential for developing the full scope of this work is visionary. Nevertheless, the definition has a practical foundation. The definition is *grounded in reality* since it rests on glimpses of possibility which this study shows exist in the actual practice of occupational therapy (see Chapters 3 to 8).

Mentally Handicapped, 1986; Zola, 1984).

In contrast, people diagnosed with mental disorders have had far less success in entering mainstream society. Such people continue to experience negative social stigma and segregation (Doerner, 1981; Ryan, 1976; Scheff, 1975; Simmons, 1982; Valentine & Capponi, 1989). They experience powerlessness as both a symptom and consequence of mental disturbance (Bachrach, 1988; Cockerham, 1989). Some theorists view oppressive social conditions as causing mental disturbances while others see mental disturbances as a result of a downward drift in social class (Scheff, 1963; Szasz, 1961). Regardless of their origin, mental disturbances reduce people's ability to think, feel and act. Particularly for those with long standing disturbances, the experience of mental problems interacts with the contextual experiences of everyday life. If disturbances persist, people are highly likely to live a marginalized existence with limited employment, housing, recreation and other opportunities (Hollingshead & Redlich, 1958; Liberman, 1985; Woodside, 1991). For some people, their experiences and conditions of powerlessness are extended through the process of psychiatric diagnosis and treatment (Goffman, 1961; Rosenhan, 1975; Smith, 1975; Szasz, 1961). While there are ideological and other problems associated with psychiatric diagnosis (Chesler, 1972; Ehrenreich & English, 1979; Ingleby, 1981; Ralph, 1983; Smith & David, 1975; Waitzkin, 1989), I agree with the psychiatric standpoint that mental disturbances exist. I believe that people's experiences of mental disturbance arise in an interaction between biological, psychological and social processes.

1.4 Why is Occupational Therapy Concerned with 'Enabling Empowerment'?

Occupational therapy has an historical vision and practice which resembles the work of enabling empowerment. Concern with empowerment is grounded in occupational therapy's foundational beliefs in the power of occupations to influence people's mental, physical and

spiritual health (Meyer, 1922; Reilly, 1962; Reed, 1984). Furthermore, this profession is grounded in a moral commitment to work with persons hidden from society because of physical limitations, mental disturbances or poverty which historically relegated people to asylums and workhouses. Occupational therapy's commitment has long been to promote personal growth and to create institutional and community environments which would soothe the mind and enable people to flourish despite physical, mental or social difficulties (Dunton, 1919; Meyer, 1922). Consistent with social interests in the 'environment', occupational therapy has a little known heritage in social activism (Frank, 1992). Although other areas of practice are more prevalent and publicly known, the profession has almost a century of activist involvement in changing conditions in homes, schools, public buildings and work places (Tate, 1974)⁵.

Today occupational therapy retains concern for people whose congenital 'abnormalities', trauma, illness, aging, or social disadvantages limit their occupational potential (Canadian Association of Occupational Therapists, 1991, 1994). Occupational therapy's mental health work is particularly concerned with powerlessness associated with mental disturbances (Canadian Association of Occupational Therapists, 1993a). Recent research has even begun to analyze occupational therapy using the language and concepts of empowerment (Kari & Michels, 1991; Pizzi, 1992).

Furthermore, occupational therapy seems to be founded on educational ideas and practices oriented to enabling people to develop their potential in everyday life and to structure conditions which support their development. To display occupational therapy's educational foundation, my Master of Adult Education thesis showed that twelve principles of occupational therapy practice are consistent with core principles of adult education and community development (Townsend-Baglolle, 1982). In addition, occupational therapy's generic conceptual framework

⁵ Occupational therapy's social activism is analyzed in Chapters 4 to 8.

includes a "teaching learning process", defined as a "fundamental element of intervention" (Canadian Association of Occupational Therapists, 1991, pp. 65-66). Occupational therapy has historically educated people by structuring experiences in 'everyday life' which enable a "satisfactory adjustment to community life" even when people have an illness or disability (LeVesconte, 1935, p. 12).

In addition, some occupational therapy literature explicitly describes practice with reference to various learning processes. For instance, neurological learning processes have long been described by the profession's neurodevelopmental and sensory integration practitioners (Ayres, 1981; Schwartz, 1985). In addition, psychological learning processes have been described as a basic interest in psychosocial forms of practice (Canadian Association of Occupational Therapists, 1993a). Of note, occupational therapy literature over the century is sprinkled with the word 'enabling' to describe therapists' work of facilitating, coaching, and otherwise educating people to participate in everyday life. Practice is actually a 'developmentally appropriate' form of education since it promotes developmental learning from early infancy to old age (Banus, 1979; Canadian Association of Occupational Therapists, 1991; Llorens, 1970). There is even growing clarity in occupational therapy that this is an educational practice of "enablement" (Polatajko, 1992) which educates people to develop meaningful patterns of occupation.

1.5 How is Occupational Therapy Generally Known?

Despite examples of historical and contemporary practice which resemble the work of enabling empowerment, occupational therapy developed as a profession in the 19th century using the concepts, categories and practice patterns of medicine (Maxwell & Maxwell, 1983). The moral commitment to working with disadvantaged people was formally organized as a component

of psychiatry's "moral treatment" (Bockoven, 1971; Reed, 1984). By the beginning of the 20th century, occupational workers were officially known as occupation aides or reconstruction aides. Most of these people had been teachers, nurses, social workers or unemployed upper class women, often wishing to contribute to the rehabilitation of soldiers wounded in World War I (Frank, 1992; Low, 1992)⁶.

With renewed purpose in contributing to the war effort, occupational therapy became what the sociology of work describes as an emerging profession (Bucher & Strauss, 1961; Holland, 1972). The claim for professional status was based on having a title, discourse and self-regulating practice. Ideas, values and beliefs about human occupation were developed to define a curriculum and standards which, in North America, have always been organized within the university academy (Robinson, 1981)⁷. Occupational therapy's work does not lie within medicine's 'division of labour' (Caplow, 1978; Hughes, 1958; Wilensky, 1964). Nevertheless, the profession's status developed through medical sponsorship (Maxwell & Maxwell, 1983). Not surprisingly, occupational therapy developed its theoretical base using medical discourse and conditions (Trider, 1972). Until the late 1960's, occupational therapists even wore the starched dresses and caps common in medical institutions. Even in the 1990's, all but two Canadian universities administer occupational therapy education as a component of Rehabilitation Medicine. Furthermore, the profession has developed a highly technical practice which seems to reflect the concern in medicine and society with being scientific (Driver, 1968; Xerxa, 1992). Modern occupational therapy has become so profoundly connected with medicine that it is generally

⁶ While early occupational work was done by men and women, the new aides were virtually all women even though the actual work is not traditional 'women's work' (Litterst, 1992).

⁷ In North America, occupational therapy has always been located within universities. In Europe and many other countries, occupational therapy education is organized in medical institutions, primarily hospitals, using the medical apprenticeship model.

known as an 'allied' health profession or an 'auxiliary profession' (Johnson, 1972) in relation to medicine.

In addition, occupational therapy is largely a female profession which continues to derive status from its relation with medicine which has historically been a male profession (Hearn, 1982; Crompton, 1987; McNeil, 1987; Murgatroyd, 1982). Today, almost 80% of practice continues to be in medical institutions, with women constituting almost 96% of its practitioners (Canadian Association of Occupational Therapists, 1993b). In 1918, the Canadian Association of Occupational Therapists (CAOT) was formed to promote occupational therapy (Howland, 1944). However, with ongoing medical sponsorship, it was 1968 before CAOT elected an occupational therapist rather than a physician as President (Canadian Association of Occupational Therapists, 1968).

Of particular interest in this thesis is the place of mental health practice within occupational therapy. Despite the profession's origins in psychiatric asylums (Friedland & Renwick, 1993; McCullough, 1989; Renwick, Friedland, Sernas & Raybould, 1990), occupational therapy's mental health practice has generally had little visibility either within or outside the profession. Currently, only 839 (16.5%) out of 5080 Canadian occupational therapists registered by CAOT in 1992 identify general or specific areas of "mental dysfunction" as their area of speciality (Canadian Association of Occupational Therapists, 1993b). This is a considerable decline even since 1987 when 744 (19.4%) out of 3830 therapists identified mental dysfunction as their speciality (Canadian Association of Occupational Therapists, 1988). Concern that mental health practice is such a small proportion of occupational therapy led to the development of "Occupational Therapy Guidelines for Client-Centred Mental Health Practice" (Canadian Association of Occupational Therapists, 1993a). This concern also strengthened my interest in analyzing socially organized 'tensions' in occupational therapy's mental health work.

1.6 What is the Problem?

The problem prompting this study is that occupational therapy's mental health work with adults appears to have undeveloped potential as an empowerment-oriented practice of adult education. My own experience, the experience of colleagues, and a brief review of occupational therapy literature (Sections 1.4 and 1.4) point to this undeveloped potential. It seems that core features of occupational therapy include a moral commitment to help disadvantaged people, an interest in activism, and a concern for people's real life occupations. These features seem similar to features of an 'ideal empowerment-oriented practice' described in literature outside occupational therapy. Nevertheless, the development of an empowerment-oriented practice appears constrained. Of particular concern, there seem to be tensions which extend beyond everyday interactions to the social organization of practice. Occupational therapy appears to be organized more around medical than empowerment interests.

I define the problem as educational by defining 'enabling empowerment' as educational work. Moreover, the problem is foundational to education. Specifically, the problem facing occupational therapy in developing its educational interest in enabling empowerment is that the critical social science foundation of this work seems undeveloped. Research with occupational therapy has states that tensions exist in occupational therapy's historically organized relation with medicine (Kielhofner, 1992). However, no research has analyzed how occupational therapy actually works within a medical context. Of personal interest, no analyses have examined the social organization of occupational therapy's mental health work. As well, no analyses have examined occupational therapy's potential to develop as an educational practice oriented to enabling empowerment. Therefore, the question addressed in this study is: What are the possibilities and constraints for enabling empowerment in adults who attend transitional mental health programs?

1.7 What is Known about 'Tensions' in Occupational Therapy?

Four sources illuminate the problem of tensions in occupational therapy: practitioners' own voices, occupational therapy literature, literature on professions in general, and literature on the organization of state managed services.

First, the experience of tensions is subjectively known by occupational therapists, such as the seven who participated in the study. For instance, 'Jill' describes tensions around being different from other health professionals. She contrasts occupational therapy with the "care giver" approach of another worker:

...he doesn't know how to get people involved. He's essentially a care giver.
(Observation of Jill, JOB01, 559-561)¹

Jill's comments exhibit both stress and pride in keeping up with her different type of practice. However, she does not speak about being different. She interprets tensions as a feature of pressured time in dealing with the complexities of enabling multiple people to organize their own lives. As Jill says:

It's crazy - I used to have 80 people on my caseload before the other therapist came - now we still carry about 40 people each and that's too much - I used to be taking work home and doing it at one o'clock in the morning - there are so few community resources here that you have to keep working away and getting involved in far more than in some other communities. (Observation of Jill, JOR01, 687-697)

I've sort of perfected the art of doing two or three things at the same time. The one thing I really try to do is - if I'm interviewing clients, and I don't want to be fiddling with other things, but if the phone is ringing, or I'm put on hold - I'll usually have something next to me, so that I can start making notes or something like that. (Interview with Jill, JINTOT01, 2908-2918)

In contrast with Jill, Pat highlights tensions as a sense of inadequacy in being different. While she is proud of the uniqueness of occupational therapy's practice, she also perceives a lack

¹ 'Jill' is the code name for the occupational therapist in Site J. The quote is extracted from fieldnotes coded as the first day (01) of observation (OB) of Jill's work (J). (See also CODE NAMES, p. xv, and APPENDIX A)

of fit which casts her as deficient in relation to her professional team members.

I've had this activity background - this occupational therapy background; but so many of the things that I've found myself doing here, I'm not trained for. (Interview with Pat, PINT08, 301-305)

As Pat says, occupational therapists feel deficient but in other ways liberated by being different from other professions.

I think the liberating part is that I can go around and have these interactions with people in ways that people of other disciplines can't because there is just such a gap between their training and someone else's. The breadth of occupational therapy actually allows therapists to close gaps between ourselves and people. We are not so different from them when it comes down to doing ordinary activities. We can relate to many people. We offer a bridge in our transitional work since we know something about the real work of people. (Interview with Pat, PINTOT07, 586-590)

Rather than identify occupational therapy's uniqueness as difference, deficiency or liberation, Rita expresses the tension of feeling powerlessness in using common everyday activities which carry little power "in the sense of impressing the big wigs" (Interview with Rita, RINTOT09, 272-274). Rita describes her practical decision to address this feeling by choosing situations which offer some possibility for using her "unique skills" as an occupational therapist.

I had to look at where my unique skills could be utilized the best. And also what I would like, you know, where my preferences were for my enjoying my work. (Interview with Rita, RINTOT03, 522-527)

She also addresses feeling powerless by talking with the team about tensions in doing "occupational therapy things" given limited time and energy for the overall job.

I've been feeling overwhelmed by the number of requests to do occupational therapy things - particularly things like linking people to leisure interests...so what I'm asking for is understanding from the rest of the team when I say no to some of your requests...I am more assertive [as the team has suggested] and state my limits, but then I'm asked to take six more cases. I know I need to be more assertive but I'm asking for team support in trying to set my limits...The program requires staff to have a lot of self-direction. That's all very well but it takes energy and needs support. (Observation of Rita, ROB23, 251-329)

May highlights tensions associated with operating as a "go between" between the worlds

of professionals and ordinary people.

You have to be careful and not use too much professional jargon. You know, if you're working with a self-help group, you have to talk to them in normal language. And it's ok then to go back to the professional people and use the professional jargon with them. They expect you to. And that's ok. So you sort of have to be able to go between those two things. (Interview with May, MINTOT01, 1151-1161)

While May describes tensions of being a "go between" in terms of shifting language, Carol points to tensions around preserving confidentiality between the professional world of psychiatry and the ordinary world of work. She organizes part-time, trial work experiences where people practice being supervised in hospital industries such as food services or maintenance. When she approaches the supervisors of these units, she describes what people can do.

We try to give them information that's only pertinent to them for working on the job - no real history or background of their illness or anything like that - everything is very confidential. If there's anything, sort of relating to their ability to work - for example that they may need a time out - or that they may need a quiet area for working, we may say something about the amount of responsibility they are ready to take on. But we only give them information that's really needed. (Interview with Carol, CINTOT01, 539-552)

Nora articulates another facet of tensions surrounding the documentation of practice. As she talks about empowerment, she points to the problem of documentation connected with being part of a hospital:

...because that keeps you quite attached to the medical model of stuff although you're trying to work with something that's very different...the time you have to spend fulfilling hospital quality assurance and program kinds of stuff...charting, for statistics, all that kind of stuff. And also because there's a different kind of mind-set if you're doing that. (Interview with Nora, NINTOT02, 793-823)

Conversely, Bev talks about tensions in trying to extend practice beyond hospital facilities. Efforts to reach out appear to be appreciated by the team but are financially unrecognized by the hospital.

I don't do it much. I do go out. I'm just not re-imbursed for it. I get my pay for working. But I'm not given mileage. It's not recognized that I actually do it. (Interview with Bev, BINTOT02, 386-390)

In describing practice, Bev articulates the belief that occupational therapy has undeveloped potential. But the tension is one of being "not well developed".

The occupational therapy role in mental health is not well developed ...we're not very clear on the role ourselves. (Observation of Bev, BOB02, 70-75)

Bev even points to employment in a hospital setting as a source of tension.

Just the fact that I'm working here, and I'm working in [a hospital-based site] such as this, means that I'm working in contradiction to some of my values and beliefs in what I could be doing to empower people. I work here because this is where I can get paid. This is where things are established. But that's in contradiction to what I preach about people learning to be responsible for themselves in the community. (Interview with Bev, BINTOT04, 294-305)

These statements suggest a variety of tensions. In particular, they point to tensions around getting people involved rather than caring for them; working with such large caseloads and paperwork requirements that there is little time to help people become involved in their own communities; encouraging people to take on responsibility yet retaining control of decisions about their need for 'time out'; having a background in 'activity' yet finding that this background does not fit with the work of other team members in mental health programs; offering transitional bridges while keeping track of people on behalf of referring psychiatrists; and working in hospitals rather than in communities where people live. These descriptions highlight difficulties in attempting to create bridges for and with people who are struggling with transitions between hospital and everyday life.

Second, a sense of tensions is displayed in some occupational therapy literature. In particular, there are repeated references to tensions in occupational therapy's relation with medicine. Medicine seems to be taken as the norm. Whereupon, debates have arisen around whether occupational therapy is a "diffident" profession with little sense of its own purpose

separate from medicine (Kielhofner, 1985b; Maxwell & Maxwell, 1978). Other debates have been over differences in the views of order and disorder in medicine and occupational therapy (Kielhofner, 1992; Rogers, 1982). Some authors have pointed to tensions arising when occupational therapy fails to define its own management criteria within medically-defined health systems (Carswell-Opzoomer, 1990; Chilton, 1990). In the 1990's, some authors have examined tensions in developing the ideology and epistemology of occupational therapy with reference to this being a female dominated profession (Litterst, 1992; Yerxa, 1992). Tensions arising from the domination of occupational therapy by women and its gender relation with medicine have been analyzed most recently through questions about feminist practice and recruitment (Frank, 1992; Litterst, 1992; Readman, 1992). Overall, occupational therapy literature points to tensions in this profession's connections with medicine and health services management.

A third source adds to the sense that there are fundamental tensions in occupational therapy. Research in fields other than occupational therapy suggests that occupational therapy's experience of tensions may exist because occupational therapy, being a profession, has a greater likelihood of dominating people than of enabling their empowerment. Critical analyses of professions, such as medicine and law, describe professional practice as dominant in relations with patients or clients (Derber, 1982; Dingwall and Lewis, 1983; Freidson, 1986; Illich, 1977; Larson, 1977). The historical patterns of professional dominance described in these critiques seem incompatible with an ideal practice oriented to 'enabling empowerment' (defined at end of Section 1.2). Of note, psychology (Rappaport, 1987) and social work (Baily & Brake, 1975; Kilian, 1988; Pinderhughes, 1983) have already articulated sensitivity to some constraints which professions face if they intend to enable the empowerment of those who use professional services.

A fourth source suggests that tensions in occupational therapy may lie in the hierarchical organization of state managed health and welfare services (Coburn, D'Arcy, Torrence & New,

1987; Gough, 1979; Ingleby, 1981; Navarro, 1986, 1978; Panitch, 1977; Ralph, 1983). Some research points to tensions which arise when status and authority produce unequal power positions in society (Daudi, 1986; Habermas, 1984; Smith, 1987). Other research points to tensions between professional interests in human development and the state's interest in using mental health professionals to control deviance which threatens institutions of power (Cohen & Scull, 1983; Conrad & Schneider, 1980; Foucault, 1965; Szasz, 1961; Ralph, 1983; Rothman, 1980). In addition, Marxist analyses have pointed to contradictions in promoting human development within capitalist economic structures (Gough, 1979; Moscovitch & Drover, 1981; Navarro, 1976; Ehrenreich, 1978).

Overall, this initial sketch of the experience of some occupational therapists and some occupational therapy literature indicates that tensions are known within the profession largely as problems in everyday practice. There has been little critical analysis of the discourse of practice or socially organized connections between occupational therapy, medicine, health services management, other professions and community practices. Furthermore, research seems to be based largely on taken-for-granted ideas, language and practices for working with people in medical institutions (Douglas, 1970; Garfinkel, 1967).

Conversely, research outside occupational therapy illuminates the systemic organization of dominant practices in society. However, this research locates tensions in typically dominant professional and state practices without reference to empowerment-oriented professions such as occupational therapy. Moreover, critical research tends to focus on constraints without showing possibilities in which a professional practice might enable empowerment rather than to dominate.

From studies to date, then, it appears that research needs to acknowledge occupational therapists' experience of tensions but investigate how tensions are socially organized beyond that experience.

1.8 What is the Significance of the Study?

The direct significance of this study is its potential to illuminate socially organized tensions which constrain the development of empowerment-oriented features in occupational therapy's mental health work. Thus, the immediate significance is professional. In essence, an aim of the thesis is to foster occupational therapy's empowerment so that the profession may more fully enable empowerment in others.

However, this study also holds significance for other professional practices. The contribution to adult education is that the study analyzes features which are central in current debates and research: recognizing learners as active persons, enabling learners to connect social action with individual learning, collaborating in partnerships with learners, engaging learners in real rather than simulated learning, enabling learners to engage in risk taking and transformative change, and enabling learners to participate as valued and contributing citizens within society. There is also significance for clinical psychology, social work, health education and other professional practices which claim interests in enabling empowerment.

Ultimately, the study has social significance. As occupational therapy develops its vision and practice, this profession will be better able to take its place in the world with social movements working towards the empowerment of those without power. Therefore, the social significance is international. If occupational therapy can organize institutions and society in general to support empowerment-oriented processes and practices, empowerment-oriented professions may actually be able to enable empowerment rather than to perpetuate professional dominance. If some professions discover that they might develop features which support people in their struggle for empowerment, the more far reaching significance may be a contribution to social justice.

1.9 Looking Ahead

The thesis proceeds by describing institutional ethnography as both theory and method (Chapter 2). The final chapter reviews my experience in conducting this study, and by discussing implications of the analysis for practice, education and research. (Chapter 10).

In the intervening chapters, the institutional ethnography investigates tensions in occupational therapy's mental health work with adults diagnosed with mental disorders who are attending transitional mental health programs in the institutional context of provincial mental health services. The thesis analyzes tensions surrounding six core features of occupational therapy's vision and practice (Chapters 3 to 8). Each of these core features was selected because it was identified as central in occupational therapy's historical and current philosophy and also central to an ideal empowerment-oriented practice as described in literature outside occupational therapy. The core features are also present as 'glimpses of possibility' in the actual practice of occupational therapy. The six 'ideal' core features are that professionals:

1. recognize people as active 'persons' who have power to act in the world;
2. recognize that individual and social action is interdependently connected;
3. include people as collaborative decision making partners;
4. structure an educational practice to enable empowerment in the real world;
5. challenge and guide people through the risk taking required to produce transformative change; and,
6. promote the development of a public ethical commitment to global inclusiveness.

Chapters 3 to 8 all follow the same format. Each chapter opens by describing an ideal vision of one core feature of an empowerment-oriented practice using literature outside occupational therapy. Glimpses and tensions related to this ideal are then displayed in occupational therapy literature. Using study data, glimpses and tensions are also displayed in

actual practice. Each chapter highlights different aspects of actual practice as if portraits of occupational therapy have been drawn from six different standpoints. These portraits highlight occupational therapy's mental health work in 'assessment' and 'admission' (Chapter 3); 'goal setting' and 'case coordination' (Chapter 4); 'decision making' (Chapter 5); 'program philosophy' and 'funding' which structure space and time (Chapter 6); 'risk management' (Chapter 7); and 'chores', 'discharge', 'follow up', 'sheltered employment', 'social recreation' and 'special benefits' (Chapter 8). At the end, each chapter summarizes possibilities and constraints for occupational therapy to develop the specific core feature given the current organization of mental health services.

The six analyses are then synthesized into the central interpretive argument of the thesis (Chapter 9). Whereas Chapters 3 to 8 look at tensions which surround and are, thus, located within each feature, Chapter 9 describes patterns in tensions which emerge in looking across each of the six features. This second approach shows how occupational therapy actually works when tensions surrounding each feature are grouped. Chapter 9 pulls the institutional analysis together to reveal a central tension organizing occupational therapy's mental health work with adults in transitional mental health programs.

One final point is important to note before proceeding. The account is written in the present tense. Unlike studies which report on past events or the results of experiments which have ended, this is an ethnography of occupational therapy's ongoing social relations. Although my data record instances of practice which are now in the past, the account records the way occupational therapy relations are currently organized in Atlantic and general Canadian society. Throughout, I write in the first person to acknowledge my presence as a researcher who is actively engaged in investigating practice.

CHAPTER 2

THEORY AND METHOD

2.1 Introduction

The study is an institutional ethnography of occupational therapy's mental health work. Institutional ethnography is a qualitative approach for studying how practices, such as occupational therapy, actually work (Smith, 1987). Here, institutional ethnography has been used to examine what occupational therapists actually do and say in the actual material conditions of everyday practice. The 'institutional' feature shifts analysis away from the particular experiences of occupational therapists in particular conditions, as would be typical of ethnographic research on everyday experience (Ellen, 1984; Hammersley & Atkinson, 1983). Instead, this approach produces an account which shows how everyday experience is organized by generalizing institutional processes and practices which are predominantly textual (Smith, 1990a). Furthermore, the analysis displays how the everyday world is ideologically organized by the "relations of ruling" in an institution such as mental health services (Smith, 1990b, pp. 14-18). The method is grounded by taking a standpoint in the everyday world. From that standpoint, the actual activities and conditions of the everyday world are traced to the ruling institutional processes and practices which are often invisible to people from a standpoint in their everyday work. In other words, an institutional ethnography displays how power organizes and is organized by 'institutional social relations'¹.

¹ The term 'institutional social relations' here does not refer to interactional processes. Instead, institutional social relations are ideological and serve to coordinate and control interconnected practices between different workers in the same or different locations and time (Smith, 1987).

Consistent with this type of ethnography, the study was designed with three interconnected analytic processes²: data collection on the actions, talk and material conditions of actual work; tracing the social processes which connect this with the work of others; and, analysis of the institutional organization of the work. Data were collected through three methods common to ethnography: participant observation, interview, and documentary review (Ellen, 1984; Hammersley & Atkinson, 1983). Each process is analytic in that it shapes the investigation consistent with the theoretical framework of institutional ethnography.

This chapter describes how and why the study was conducted as it was. The description proceeds as the study did, from identification of the problem to analysis.

2.2 Making the Everyday World Problematic

An institutional ethnography begins its analysis by locating the problem for inquiry in people's actual experience of the everyday world. The type of problem of interest for this type of inquiry is what Smith variously describes as a "disjuncture", "bifurcation of consciousness", "line of fault" or "point of rupture"³ between subjective experience in the everyday world and the world as it is otherwise known (Smith, 1987). As well, problems of disjuncture are investigated with active knowers in the real world. The commitment to begin an investigation with active knowers locates the research standpoint within the everyday world. From this standpoint, neither the everyday world nor disjunctures are theorized as research objects. Instead, the experience of everyday practice provides a window on active ongoing processes and

² The analysis actually begins by making the everyday world problematic (see Chapter 1.6 and Chapter 2.2). Therefore, the three processes refer to analysis of ethnographic data.

³ The terms are not synonymous. However, each describes those points of contradiction, tension, separation or incongruence experienced between what is known of the everyday world and the way it is otherwise constructed, particularly by the official, often textual, practices of an institution.

practices which organize broad institutional social relations (see Footnote 1 above, and Section 2.5). The analysis seeks to explain how everyday experience is socially organized such that a disjuncture exists.

The problem of disjuncture investigated in this study is that of socially organized 'tensions' in occupational therapy's mental health work (see Chapter 1.6).

2.3 Subject Selection and the Collection of Data on Practice in the Everyday World

Having located a problem of disjuncture, an institutional ethnography designs data collection as a step in analysis. Data collection begins from a standpoint within everyday practice by recording actual the 'work processes' and the actual material conditions (space, time, funding, etc.) in which these work processes occur. By 'work processes', Smith refers to people's actual activities, including action and talk beyond the 'work' defined by employment categories⁴. Thus an everyday practice consists of sets of work processes oriented to a particular function whether that function be the practice of homemaking, volunteer work, occupational therapy or law.

A standpoint in everyday practice grounds but does not limit the analysis to an interpretation of the observable features of that practice. To understand how the everyday world is embedded in historical and contemporary social relations, data collection extends beyond the everyday world to include the documentation and other social processes which govern those activities (see Sections 2.4 and 2.5).

For this study, seven occupational therapists were selected for gathering data on a theoretical sample (Glaser, 1978) of occupational therapy's everyday mental health work. A number of occupational therapists were selected since everyday experience appeared to differ

⁴ I note that, as an occupational therapist, I found this definition of work easy to comprehend since it is highly congruent with occupational therapy's broad definition of occupations (see 'OCCUPATION' DEFINITIONS, p.xii-xiv).

considerably in different settings. Therefore, it was necessary to intensify data in order to distinguish general practice patterns from variations. The seven sites (Coded as: B, C, J, M, N, P and R as explained in CODE NAMES, p.xv, and APPENDIX A) included day programs, out-patient services or community mental health services in the four provinces of Atlantic Canada: New Brunswick, Newfoundland, Nova Scotia and Prince Edward Island. These criteria left only a small group of occupational therapists to approach. However, selection purposely ensured that at least one site was in each province. The geographic criterion was added to protect therapists' anonymity. Anonymity would be extremely difficult to protect in the small occupational therapy and mental health community of this region if data were drawn from only one occupational therapist's experience or from the few therapists in any one province. Without multiple sites, it would be too easy to read the data as an evaluation of one occupational therapist's practice. As well, by including therapists who practice throughout the Atlantic Region, the analysis offers recommendations for practice, research, and the regional occupational therapy education program at Dalhousie University. This last function attends to the social agenda of an institutional ethnography. By locating the problem for inquiry in the real activities of the everyday world, the analysis is also a blueprint for changing the institutional processes and practices in which those activities are embedded (see Section 2.5).

The data collection process (typical of most ethnographic studies) can be pictured as a funnel. Data collection begins broadly to record the full scope of a particular practice. The focus of data collection gradually narrows until there is "saturation" (Hammersley and Atkinson, 1983). In an institutional ethnography, saturation occurs when sufficient data have been collected to record how everyday practice actually works within an institutional framework. There is no absolute point at which data collection has been completed. Data collection continued in this study until no new variations or contradictions emerged in everyday practice. Data on the

institutional organization of practice were collected as questions arose on site but also throughout the analysis and writing of the thesis (see Section 2.7, Rigor).

To record the full scope of practice, data were collected in the first two sites (Sites P and R) for eight and six weeks respectively; full time in each site (see Figure 1). During the six weeks between data gathering in these two sites, initial analytic ideas were developed and presented for response from 'Pat', the occupational therapist in Site P. After data were collected in the second site, analytic ideas from the first site were developed and presented to 'Rita', the occupational therapist in Site R. After reflection on Rita's comments, data were collected in Site N in which the program philosophy and facility differ from the first two sites. Data were collected with 'Nora' for one week in order to be able to confirm core features, variations and additional contradictions presented in these circumstances. After discussion of analytic ideas with Nora, data were collected for one week in Site B which offered a view of practice where 'Bev' had more administrative duties than did occupational therapists in the first three sites. Data were needed to distinguish occupational therapy practice from variations associated with administrative practice. After reviewing analytic ideas with Bev, data collection was extended to document the practice of 'Jill' and 'Carol' in Sites J and C respectively. These two sites were visited to attend to variations associated with different managerial lines of authority. Site M, with 'May', was included to examine practice oriented more to individual than group work. Sites were added until no new variations and contradictions were documented and at least one site had been visited in each of the provinces of Atlantic Canada. Documents as well as participant observation and interview data were collected in the first six sites. Data in Site M were collected only through interview.

Figure 1

The Funnel Process of Data Collection

Site P: 'Pat' *	psychoeducation program** hospital	8 weeks 30 OB* 8 INT extensive DOC
Site R: 'Rita'	psychoeducation program hospital	6 weeks 30 OB 10 INT extensive DOC
Site N: 'Nora'	psychosocial rehabilitation program renovated 'clubhouse'	1 week 5 OB 3 INT few DOC
Site B: 'Bev'	psychoeducation program hospital	4 days 4 OB 4 INT few DOC
Site J: 'Jill'	psychosocial rehabilitation program renovated house	3 days 3 OB 1 INT few DOC
Site C: 'Carol'	psychoeducation program hospital	2 days 2 OB 2 INT few DOC
Site M: 'May'	psychoeducation program renovated house	1/2 day 1 INT

* See CODE NAMES, p. xv, and APPENDIX A for list of sites, code names and data file codes
OB = observation days; INT = interviews; DOC = documents

** See Chapter 6.5 for program descriptions
Most programs do not adhere strictly to one philosophy
Sites were selected according to program philosophy, organizational features or province

Data collection was analytic in that it incorporated participant observation, interview and documentary review consistent with the theoretical approach of institutional ethnography. The data recorded occupational therapists' real actions and talk. They also recorded the people involved, location, time frame, equipment and supplies which create the material conditions of everyday practice. In addition, program descriptions, philosophic statements, policies, procedures, budgets, legislation and other institutional data were collected to show the practical processes and practices used to govern mental health services (see also Section 2.5).

As an example, a summary of one session in Site R with Rita shows the types of data collected from a standpoint within everyday practice. One day Rita, another professional team member and myself sat in a room with eight people admitted to the program. We all talked and went through role plays without props for about an hour. At the start of the session, Rita outlined general plans and asked people to suggest topics and activities possible within the given place, time and general topic. The other professional acted as a co-therapist, prompting Rita or adding comments while Rita initiated questions and facilitated discussion unobtrusively. Rita attended to each individual and encouraged group members to respond to each other. At the end of the day in which this session occurred, I recorded Rita's actions and talk in that session and in other parts of the day. Notes include reference to the numbers of people attending the session and the interaction with these people and the other staff member with Rita. I also noted the location, day of the week, time of day, equipment and supplies.

Data collection extends into the second analytic process (see Section 2.4). Interviews with Rita were used to ask about the connections between sessions such as that described above and the institutional processes and practices which organize that work. As well, I collected the program description, policies and procedures, budget, and other documentation related to this and other sessions. This detailed recording continued in Site R over the six weeks of observation.

Data collection on everyday practice and related organizational processes occurred with six occupational therapists, excluding May since there was no observation in Site M. As questions, analytic ideas and other thoughts came to mind, these were recorded as "Reflections" in observation and interview notes or in a Reflective Log which I kept throughout data collection.

In total, the data collected in this study include:

1. 74 days of participant observation data of six therapists (excluding Site M) recording:
 - a) a variety of individual and group program activities
 - b) 20 team meetings described as 'rounds'
 - c) 20 weekly team meetings
 - d) over 74 daily planning meetings (sometimes more than once per day)
 - e) record keeping (particularly health records and the time and case data required for management information systems)
 - f) miscellaneous (stock taking, purchasing, staff supervision, community outings, planning with community representatives, and other activities)
2. 30 interviews with seven occupational therapists
3. 30 interviews with 27 team members and administrators
4. 10 interviews with 10 people attending the programs
5. A file drawer of documents used in six programs: e.g., program brochures, job descriptions, forms for health records, policies, procedures, time record sheets, program satisfaction surveys, quality assurance protocols, samples of monthly data sheets
6. Two large handwritten Reflective Log books (separate from observation 'fieldnotes')

2.4 Analyzing Connections

The second process in an institutional ethnography involves tracing how the work being studied is connected with other types of work in the same institution. This too is an analytic process. It sets institutional ethnography on an analytic route divergent from ethnographies which explore meanings, interpretive schemes, practical reasoning or other interactional features of everyday culture. An institutional ethnography displays how actual experience is "embedded in the particular historical social relations that determine that experience" (Smith, 1987, p. 49). The

analytic route discovers how actual work is embedded in 'institutional' social processes which coordinate and control diverse types of practice within a particular institution. As Smith states:

We begin with a knower, a subject, whose everyday world is determined, shaped, organized by social processes beyond her experience and arising out of the interrelations of many such experienced worlds. They are relations that coordinate and codetermine the worlds, activities, and experiences of people entered into them at different points. (Smith, 1987, p. 134)

Smith advocates that study begin with a "knower, a subject" in the everyday world. However, the everyday world is "shaped, organized by social processes" which arise in the "interrelations of many such experienced worlds". These "social" processes are what organize the everyday actions, talk and material conditions of a particular practice, i.e., the sets of work processes which comprise everyday practice. Therefore, the task of a researcher using this method is to investigate how social processes invisibly "coordinate" and "codetermine" the everyday practice of a particular knower/subject.

The second analytic process begins during data collection. As indicated above (Section 2.3), I not only documented Rita's actions and talk but also the material and documentary conditions associated with her work. Continuing with the example of Rita's work in guiding a discussion and role play group session, I noted how her actions and talk in this group and other work processes were reported (and not reported) at team meetings and rounds. I interviewed Rita and other team members to determine how the place, time and general plans for the group were decided. Who did this work of deciding? When? With what participation by people in the program? Who had arranged the room? How was the equipment paid for? What conditions allowed for use of alternate space and facilities? How was the group activity documented within the management information system of the program? What categories organized their work into time units? What information on clients and their work processes was collected? How were group processes selected and documented? What criteria were used to gauge the success of these

groups? Who defined these criteria? Who could change groups and how was it done?

Interviews were used to clarify observations and to determine document collection. From observations and interviews, it appeared relevant to collect documents which might explain, display or further clarify practice. These included schedules, activity plans, group exercise protocols, policies and procedures for accountability, policies on decision making and responsibility, quality assurance protocols, risk and crisis management policies and procedures, liability legislation, confidentiality legislation, funding policies, and other related documents. Prompted by interviews or review of documents, I sought opportunities for observing therapists in particular activities, such as home visits and committee meetings, which were not readily observable during my planned observation period. In this way, the three data collection methods, participant observation, interview and documentary review, were integrated into the process of tracing how occupational therapists' work is connected to the work of others.

The process of analyzing connections extends from data collection into data management and the early stages of data analysis. After the completion of data collection in the seven sites, data were coded to group occupational therapy's actual work processes. Sorting data by actual work processes, rather than interpretive themes such as 'choice', is conceptually consistent with institutional ethnography. Codes retain recognition of the material conditions of everyday practice as a standpoint from which to examine the social organization of these work processes. Coding was first done by converting the transcripts of observations and interviews for use with ETHNOGRAPH, a microcomputer software package (see CODE NAMES, p.xv, and APPENDIX A). Transcribed observation and interview notes were coded to identify single, multiple and overlapping work processes. Documents were filed under the most applicable work processes with notes to cross reference them to other work processes.

Occupational therapy involves a wide range of work processes from coaching people to

speak to city officials to reporting at medical rounds. I found that it took considerable reflection (and 12 main revisions of code lists) to develop code categories for dividing and analyzing the data. Finally, I settled on 52 codes to divide the transcribed data into broadly defined work processes: 13 codes to categorize the philosophic and organizational work of defining programs; 24 codes to categorize therapists' work with clients; and, 15 codes to categorize therapists' managerial work separate from contact with clients (see APPENDIX B).

Each revision of the code list clarified connections between occupational therapists' work and that of others. To illustrate, data codes on structuring the program philosophy and weekly activities, such as for groups like the one observed with Rita, were listed together. I recognized that this philosophic 'structuring' work provided evidence of connections between occupational therapy and other professions, particularly psychiatry and psychology. Then, a second set of work processes which involved the people attending these programs were listed together. This collection of work processes provided evidence of connections between occupational therapy and people's families, work places and others outside programs. These work processes included: individual and group sessions about the self and everyday life; helping people to find community support groups; investigating employment, housing and social recreation programs; and determining regulations for financial assistance. A third set of processes were listed together to show occupational therapy's administrative work, particularly with reference to occupational therapy's connections with mental health services management. These were the processes of preparing budgets for supplies used in everyday activities, documenting time in a 'workload measurement system', 'case management', and data on numbers and types of cases seen (see particularly Chapter 4 for analysis of these documentary processes). As analytic ideas arose around interconnections, these were transcribed as 'Reflections'.

2.5 Analysis of the Practice of Ideology

The third process of an institutional ethnography extends the analysis of interconnected work processes. It displays how ideological processes and practices coordinate and control interconnecting work processes to accomplish the specific functions of an institution. Here, ideology is not viewed as a theoretical framework. Rather, ideology is defined as actual processes and practices which are observable in everyday situations but which invisibly coordinate and control people's experience in the everyday world (Smith, 1987, 1990a, 1990b)⁵. The processes and practices which are used to manage institutions such as mental health services are ideological in that they categorize and incorporate the ideas, values and beliefs of a "ruling apparatus" which governs the institutional function (Smith, 1987, p.3).

Therefore, this part of the analysis shows how generalizing institutional processes and practices exist as actual activities in the material conditions of everyday life, but are organized "external to the local and particular places of one's bodily existence" (Smith, 1987, p. 84). Institutional processes and practices are shown to be ideological "generalizers of actual local experience" (p. 154). In other words, ideology is analyzed as a practical "method" of ruling rather than a theoretical idea (Smith, 1990b, p. 45). To analyze ideology, then, is to analyze how generalizing processes and practices coordinate and control interconnected practices in which different workers act on the same person or object in the same or different locations and time. The analysis of generalizing processes and practices reveals the broad social relations of an institution (see Footnote 1 in this chapter).

⁵ This definition of ideology is consistent with the definitions of power, empowerment and enabling empowerment in Chapter 1.2.

This third analytic process focuses particularly on the 'textual'⁶ practices of an institution. In institutions, work processes are coordinated and controlled to a great extent by textual practices. As used by Smith, the word 'text' refers to a wide variety of documentary media which create an account of experience. Based on this broad definition, the textual analysis may examine written materials, audiovisual records, verbal statements, measures or other forms used to represent human behaviour.

Textual practices create "objectified knowledge", meaning knowledge that is created through the textual representation of selected facts about actual experience (Smith, 1990a). These practices in particular show the disjuncture between objectified knowledge and the subjective knowledge of actual experience⁷. The aim, then, in analyzing textual practices is to examine textual "facts" as objects which form an account of what is textually "known" about people and work processes (p. 104). The textual account both displays and organizes the "objectified forms" which have been used by an institution to coordinate and control work processes "through the text" (p. 4). Furthermore, this aspect of the analysis shows how "routine documentary activities" are used to guide decision making in 'objectified management' (Cassin, 1984, pp. 3-14).

Objectified management refers simply to the management of textual objects using scientific methods which do not require face-to-face personal contact⁸. The processes of objectified management require, at the outset, the objectification of people as 'cases' or 'units'. Therefore, the conceptualization and categorization of people as cases are fundamental social

⁶ The term 'textual practices' is used broadly here. In Chapters 3 to 8, the term 'documentary practices' will appear since the only 'textual practices' investigated were various forms of documentation.

⁷ Alternately, the disjuncture is called a bifurcation of consciousness, line of fault or point of rupture by Smith (1987) (see Section 2.2).

⁸ Since objectified management relies on the objectified methods of empirical science, it is sometimes called 'scientific management'.

processes which are interconnected with the objectified management of textual facts. Management then coordinates and controls textual facts as if they are objects by using a variety of institutional processes and practices. In other words, institutional processes and practices are the mechanisms used by objectified management to "coordinate and codetermine the worlds, activities, and experiences of people entered into them at different points" (Smith, 1987, p. 134). In health services, institutional processes such as 'admission' and 'case management' are actual activities since they are part of the actual work of everyday practice. However, admission and case management are also ideological processes in that they are based on the ideas, values and beliefs of the "ruling apparatus" of health services (Smith, 1987, p.3). In essence, both cases and work are managed as objects. The products of objectified management are factual objects such as 'quality' and 'efficiency' which demonstrate the 'accountability' of work.

In particular, the analysis of textual practices shows how texts stabilize and create order out of the disorder which is subjectively known from participation in the natural disorder of face-to-face interaction (Apple, 1986, Smith, 1990a). The institutional analysis displays how texts impose a conceptual order on accounts of the work processes of everyday practice. The conceptual order is shown to be ideological in that the order is not 'disinterested' (Lukes, 1974, 1986; Smith, 1990b). Rather, the concepts and categories organize processes and practices which are relevant to the interests of those people whose work is dominant in the institution. By displaying the ideology of an institution's concepts and categories and "documentary reality", i.e., the textual facts used to account for the work of an institution, the analysis shows how anonymous interconnected processes and practices comprise an institutional ruling apparatus (Smith, 1990b, p. 144). This means that decisions based on textual practices, rather than observation and interaction, coordinate and control everyday work processes. Decisions are based on the textual facts which are considered relevant to and valued in an institution.

Moreover, these textual practices create an "organizational impregnability" since they cannot be attributed to individuals (Smith, 1990b, p. 44). The use of 'objective' facts and interconnected processes and practices makes decision making difficult to trace to the ideas and values of actual people. Nevertheless, objectified management is based on facts which have been defined as relevant to those who control management. The objectified management of selected facts, then, produces an impregnable ideological ruling apparatus. Through objectified management, the activities which are not considered relevant to an institutional function are rendered largely invisible and powerless to shape the practices within that institution (Cassin, 1990).

To complete this third analytic process, I repeatedly read and reflected on the observation, interview and documentary data on occupational therapy's mental health work and its connections with other work processes. Reading and reflection also included an ongoing review of literature within and outside occupational therapy. From literature on enabling empowerment, I knew that I needed to be particularly attentive to the processes and practices used to conceptualize, categorize, account for, organize decision making, attend to people's problems, and promote change.

The process required extensive thought to understand and trace how everyday work might connect with and be organized by various institutional processes and practices (see Chapter 10.2, Reflections on the Study). Eventually, I became aware of six core features in occupational therapy which resemble core features in an ideal empowerment-oriented practice (see APPENDIX C). I re-coded all data to group segments of interview, observation and documentary data related to each of these six features. The analytic task involved tracing activities in occupational therapy's everyday practice to institutional processes and practices. For example, the code file "DIAG" grouped evidence of the actual activities of identifying people's mental disturbances and their difficulties in everyday living. These activities were traced to the official processes of

'assessment' and 'admission' which are organized around psychiatric categories of mental disorder (Chapter 3). Similarly, I traced data to the institutional processes of 'goal setting' and 'case coordination' (Chapter 4); 'decision making' (Chapter 5); 'program philosophy', 'space' and 'time' (Chapter 6); 'risk management' (Chapter 7); and 'chores', 'discharge', 'follow up', 'sheltered employment', 'social recreation' and 'special benefits' (Chapter 8).

2.6 Ethics

A growing number of researchers, particularly those using qualitative methods, are emphasizing that ethics are not only a preliminary procedure but are integral throughout the research process to ensure that research subjects are not exploited (Hammersley & Atkinson, 1983; Kirby & McKenna, 1989; Lincoln and Guba, 1985). This is not a participatory research project in that I, as a doctoral student, am responsible for the design, data collection and final analysis. However, the study design required practitioner-researcher collaboration from the moment of ethical review to review of a late draft of this thesis. This collaboration involved a great deal of "ethics", "entry", and "field relations" activity (Hammersley and Atkinson, 1983).

Following approval by the Ethics Review Committee of the Faculty of Graduate Studies, Dalhousie University, the study was also subject to the usual guidelines and procedures for confidentiality, consent and access to information for research in each of the seven sites. 'Entry' began with the first telephone call to the occupational therapist in each site selected⁹. Informal agreement with each occupational therapist was arranged not by letter but by personal contact. Each therapist also sponsored submission of the proposal to the site-appropriate professional, administrative and hospital research ethics review personnel.

In each site, professional 'team' members, managers and ethical reviewers were all

⁹ All occupational therapists selected (see Section 2.3) agreed to participate in the research.

consulted before the research was approved. The proposal included a "Research Information" sheet (see APPENDIX D) to address the initial questions which arose in entry telephone conversations with occupational therapists. Although various consent forms for team members, managers and 'patients/clients' were included in the proposal, in the end, each site required signed consent only from the occupational therapist (see APPENDIX E). An interview guide was provided as a general outline of the types of questions associated with the research (see APPENDIX F). Occupational therapists, other professionals and managers agreed to give me access to all documents except occupational therapists' personnel records. Six sites (excluding Site M where I only requested permission to interview the occupational therapist) gave consent for my observation of all program activities and access to read but not photocopy or transcribe information from health records. To avoid misinterpretations, the six sites requested that patients/clients who were attending programs not sign consent forms so that it would be clear that occupational therapy's work was the subject of research. Instead, sites asked that fieldnotes and other data omit any identification of patients/clients. The 10 interviews conducted with patients/clients focused on their connection with the work of occupational therapy without reference to their personal situation.

On site, occupational therapists attended to patients'/clients' rights to know about research being conducted in their presence, even though they were not research subjects. They needed to know since they had the right to deny observation of situations and access to mental health records in which they would be seen interacting with the therapist whom I was observing. Therefore, occupational therapists continually explained my presence to new people saying something like:

'Liz is following me to find out what I do. But you have the right to ask her not to come into this interview or to be part of the group. There is no penalty to you if you decide to say no.'

I was welcomed to observe all activities except a few discussions about sexual matters. People accepted my presence and generally called me 'the shadow' since I went everywhere with each occupational therapist. Since the ethical commitment required for study in a mental health service was not to record anything about people attending programs, I had to pay particular attention to making unidentifiable but cross-coded references where occupational therapists interacted with these people. An ongoing ethical concern in fieldnotes and the thesis has been confidentiality to protect the anonymity of the collaborating occupational therapists. The specific arrangements made to ensure confidentiality started with the coding of sites and the names of any people observed or interviewed (See CODE NAMES, p. xv, and APPENDIX A). As well, each of the seven occupational therapists was asked to check confidentiality in a late draft of the thesis. Although each occupational therapist and possibly some team members will be able to identify a few quotes and situations, I have taken the above precautions to make data as undistinguishable as possible to those outside a site.

2.7 Rigor

Rigor in positivist studies is judged by the validity and reliability of measurement procedures and the research design (Campbell & Stanley, 1966). In contrast, rigor in an institutional ethnography lies largely in its theory and method. The analysis of an institutional ethnography has an inherent truth since it is based on an empirical account of the actual activities of real people in real practice situations. As well, assumptions about power, ideology and the social organization of everyday life are made explicit as criteria for judging truth. Truth is sustained in the ethnographic account by presenting evidence which can be traced to the actual people, method of data collection and numbered lines in the transcript which records actual activities. The account then describes how actual activities are coordinated and controlled by the

actual documentary and decision making processes used in an institution (see Sections 2.3, 2.4 and 2.5). As well, the analytic approach used to collect and analyze data is described as part of the ethnographic account to ensure that the study process could be repeated.

In addition, I considered the "trustworthiness" and "authenticity" of the study (Lincoln & Guba, 1985; Guba & Lincoln, 1989). I included observation in multiple settings until I observed no new variations or contradictions (see Figure 1, Section 2.3). Occupational therapy differs considerably in different practice settings so that I needed to observe practice until no new general features were identified. I also collected multiple, overlapping data for cross-checking analysis in observations, interviews and documentation. As well, data record actual practice rather than relying on people's reconstructed memories reported in interviews. Furthermore, I took considerable care to construct an account which rings true from the standpoint of occupational therapists who are engaged in everyday practice in mental health services. The design included occupational therapists' review of the observation and interview notes from their own program, and their reflection on early and final drafts of my analysis. In their final review, occupational therapists supplied a few clarifying details and confirmed the trustworthiness and authenticity of the data. The main point emphasized by the occupational therapists as they read the draft thesis was that people's long standing mental difficulties, as well as institutional processes and practices, present enormous barriers to overcome in their struggle for empowerment.

Furthermore, in order to ensure that my argument fully accounts for the data, I re-read and reflected on the uncoded data base after the thesis was drafted. Throughout the three analytic processes, I alternated coding, re-reading and thinking, re-coding, and so on until I gradually focused the analytic points and the overall argument. As well, I have plenty of data which display the way practice works and have checked that none of the exclusions show contradictory

or other elements of practice which would alter the analysis or negate the thesis. Initial analytic ideas went through many stages of refinement and change, not only as intellectual processes but as a physical process of revisiting the data and literature.

2.8 Generalizability

Generalizability exists as a fundamental feature of institutional ethnography. The analysis displays broad generalizing social relations which organize practice within an institution. In referring to generalizability, there is no intention to be generalizable in the statistical sense or in the conceptualization of a grand generalized theory of society. Instead, the analysis reveals how institutional processes and practices are ideological "generalizers of actual local experience" (Smith, 1987, p. 154) (see Section 2.5). This means that institutional processes and practices shape local, particular practices in general broad social relations. Although the research stance is located in specific everyday practice situations, the analysis displays how diverse particular experiences are socially organized so that core features of that experience are generalizable to all experiences which are organized within the same institutional conditions.

Since the thesis rests on the analysis derived through institutional ethnography, the argument is generalizable to much of occupational therapy's mental health work. Although the study showed local variations in practice in each site, the analysis of the social organization of occupational therapy is generalizable to all seven sites. Since mental health services are fundamentally organized within Canada's national health system, the thesis describes the generalized organization of occupational therapy's mental health work in Canada.

CHAPTER 3

‘PASSIFYING’ ACTIVE PEOPLE

3.1 Introduction

Chapter 3 is the first of six chapters analyzing practice. Section 3.2 begins the analysis by using literature outside occupational therapy to describe the first core feature of an ideal practice oriented to enabling people to become empowered: an ideal practice is person-centred, meaning that this work involves *recognizing active people* who have the potential to act in the world. In Section 3.3, occupational therapy literature is analyzed to display possibilities and constraints for developing this ideal in occupational therapy practice. Then, glimpses of possibility are shown to be present in occupational therapy’s actual practice with people diagnosed with mental disorders who attend transitional mental health programs. Glimpses consist of examples of occupational therapy’s involvement in the ‘assessment’ and ‘admission’ processes used in these programs (Section 3.4). However, other examples of occupational therapy’s work associated with assessment and admission show that development of a person-centred practice is constrained by using medical diagnoses which conceptualize and categorize people as passive patients and cases (Section 3.5). The chapter ends with a summary of the tensions surrounding the development of an ideal person-centred practice (Section 3.6). Analysis of this feature shows how the concepts and categories used by an institution to identify and provide service to people shape how active or passive people are in the processes and practices of that institution.

3.2 Recognizing Persons: An Ideal Practice

In an ideal empowerment-oriented practice, one core feature is that practice is person-centred. In a professional practice, this means that professionals recognize that the people who use professional services are active 'persons' with autonomy and power to act in their own lives, with professionals, and in society (Young, 1990). Therefore, a person-centred practice rests on particular concepts about people. Three key concepts are humanism, autonomy and equality.

One concept is humanism. Humanism is a belief which takes human experience (rather than God) as the starting point for knowledge of the self and the world (Gutting, 1989; MacIntyre, 1984). Humans are viewed as worthy beings with latent power for integrating thought and action. People live active lives in the context of society. When liberated, such as by education, this latent power enables people to exercise freedom of choice and action in shaping their lives (Freire, 1976). Humanism refutes beliefs such as behaviourism, determinism and nihilism for their devaluing of human potential to exercise power and their reductionism of human existence to scientific measurement (Maslow, 1943). Instead, humanism draws on idealism, existentialism and pragmatism which celebrate the worth and power of people to be active participants in society. People are not viewed as 'disinterested' objects without power, but as active participants in real life (Lukes, 1974; Smith, 1990b). In conceptualizing people's power to think and act, however, humanism tends to minimize economic, social and political realities which constrain individual thought and action.

Another important concept, related to humanism, is that people are capable of autonomous thought and action. Autonomy in knowledge and action are generated through people's unique interactions between the self and society (Brown, 1985; Hall, 1981). People are subjective 'knowers' with unique subjective 'expertise' based on their experience in a socially organized world (Smith, 1987). However, the capacity to think and action means that the

capacity for autonomy lies in individuals. The danger in recognizing autonomy is the tendency to idealize individualism and the potential to change society through individual action. There is a tendency to undermine the importance of social conditions in determining whether individual autonomy flourishes or is constrained (MacIntyre, 1984).

The third concept underpinning an ideal person-centred practice is articulated most clearly in literature on enlightenment, empowerment, emancipation (Fay, 1987; Habermas, 1984) and democratic education (Young, 1990; Brosio, 1990). This is the egalitarian concept of the equal worth of all people. The concept underlies an ethical belief that autonomous people of equal worth ought to have equal opportunity to develop as humans and to exercise their power to act in society. That is, humans ought to have equal opportunity to express freedom of choice and action in the world. Furthermore, those who take a critical stance argue that choice and action ought to extend to the structure of society itself. Based on this stance is the belief that people ought to have an equal 'voice' in determining the way society works (Belenky, Clinchy, Goldberger & Tarule, 1986; Freire, 1972; Smith, 1987). In an ideal practice, people are all recognized as having the capacity to generate the power required to become empowered. Such recognition implies that all people ought to have an equitable share of the power and resources of a society (Young, 1990). However, recognizing that people are equal does not mean standardizing practices and conditions such that the differences in people's characteristics and talents is suppressed.

An ideal empowerment-oriented professional practice integrates these concepts in a person-centred practice (Korten, 1984; Maguire, 1987). In essence, people are recognized as having what I will call 'active power', referring to their potential power to act in the world. In part, a person-centred practice enables people to exercise their autonomy and develop their human potential in interpersonal interactions in everyday situations (Rogers, 1969). However, an ideal

practice also enables people to become officially recognized in society as autonomous and worthy persons (Katz, 1984; Lukes, 1974; Smith, 1987; Young, 1990)¹. For example, in Canada, an ideal person-centred practice might use the Charter of Rights and Freedoms (Canada, 1982) to develop policies budgets and laws which make it possible to recognize the active power of people to be collaborating partners in institutional decision making. In North America, an ideal empowerment-oriented practice exhibits critical consciousness of constraints for people to develop active power if they are not white, middle class and male (Ellsworth, 1989, Pinderhughes, 1990).

3.3 Recognizing Patients, Cases and Clients: Occupational Therapy Literature

In 1962, Mary Reilly hypothesized "that man, through the use of his hands as they are energized by mind and will, can influence the state of his own health" (Reilly, 1962, p. 2). She was delivering her Eleanor Clarke Slagle Lecture about foundational beliefs then being re-emphasized in occupational therapy. Her point was that occupational therapists recognize people as active agents influencing their health by the power of their own actions. Since occupational therapy's foundation as a profession at the turn of this century, there have been references to occupational therapists engaging people as active participants in everyday life despite illness or disability (Frank, 1992). More recently, in her review of occupational therapy's epistemology, values and relation to medicine, Yerxa cites an "optimistic view of people" as "active, capable, free, self-directed agents" versus medicine's view of people as "passive, incompetent, constrained, sick, controlled, pawns" (Yerxa, 1992, p. 81) [my emphasis].

As well, analyses of 'clinical' reasoning in narrative studies of practice show occupational

¹ The implications of an ideal practice recognizing that individual action is embedded in the structure of society are analyzed in Chapters 4, 5 and 8. Analyses display tensions around enabling individual versus social action (Chapter 4); personal versus institutional decision making (Chapter 5); and individual (local) versus societal (global) inclusiveness (Chapter 8).

therapists 'emplotting therapeutic encounters' in which people are recognized as active, holistic, knowing subjects (Cohn, 1991; Mattingly, 1991b²). Emerging in the 1990's are analyses of differences in people's power to act associated with culture or race (Kinebanian & Stomph, 1992; Krefting, 1992; Meyers, 1992) and gender (Pierce & Frank, 1992; Pizzi, 1992; Primeau, 1992). As part of this new consciousness, occupational therapy is beginning to develop specialties which recognize people's differences as active agents. Ideas being explored include an 'Asian focus program' or a 'women's focus program' (Dillard, Andonian, Flores, Lai, MacRae & Shakir, 1992).

Moreover, since the 1980's, Canadian occupational therapists have officially referred to practice as 'client-centred' (Department of National Health and Welfare and Canadian Association of Occupational Therapists, 1983, 1986, 1987; Canadian Association of Occupational Therapists, 1991). As used in these documents, 'client-centred' practice refers to practice based on occupational therapy's belief in an active client who determines the goals and course of practice. Furthermore, a "holistic view of the individual" and "worth of the individual" are included in the generic conceptual framework of these Guidelines (p. 16). Holism and worth are concepts brought forward from occupational therapy's historical beliefs in people's own power as worthwhile beings who are integrated in body, mind and spirit (LeVesconte, 1935; Levine, 1987; Meyer, 1922; Cromwell, 1977). As well, the Guidelines include recognition of occupational therapy's "developmental perspective", affirming occupational therapy's belief that people develop as active beings (Canadian Association of Occupational Therapists, 1991, p. 16).

² Mattingly, an anthropologist, has made a major contribution to occupational therapy. In her doctoral thesis with Dr. Donald Schon of Harvard University and in subsequent studies, she analyzed occupational therapy's "clinical reasoning". She described occupational therapy as a two-bodied profession. In her view, occupational therapy integrates scientific reasoning based on medical knowledge with narrative reasoning based on knowledge of everyday life.

The Guidelines also describe and illustrate the "Interacting Elements of the Individual in a Model of Occupational Performance" (pp. 16-18). Drawn principally from theories of occupational performance' (Kielhofner, 1985a; Reed & Sanderson, 1980), the Guidelines outline concepts and categories which indicate that occupational therapy recognizes that people are active in their environment. People are conceptualized and categorized as active in three main "areas of occupational performance": "self care", "productivity" and "leisure". People are viewed as having the potential to be active in the "physical", "mental", "sociocultural" and "spiritual" components of each of these areas in an "environment" which is "physical", "social" and "cultural"³. The concepts and categories in these Guidelines are gradually being included in official assessment procedures such as the Canadian Occupational Performance Measure (COPM) (Law, Baptiste, McColl, Opzoomer, Polatajko & Pollock, 1990). As in the COPM, these procedures recognize that people have the power to be active in the assessment process.

At its core, then, occupational therapy holds an ideal person-centred vision and displays glimpses of possibility in some discourse and practice which conceptualize people as active clients and categorize them as active in everyday occupations. But there are tensions in sustaining recognition of active people in most descriptions of practice: the majority of occupational therapy literature uses a medical discourse to conceptualize and categorize patients. Patients, by definition, are passive recipients waiting 'patiently' for medical services. Despite a shifting orientation to recognizing people as clients, occupational therapists still frequently refer to people as patients and almost always describe people by their medical diagnoses⁴. For instance,

³ Recommendations for updated guidelines suggest the addition of citizenship occupations, a fourth area, as well as the addition of legal, political and economic elements in the environment (Blain, Townsend, Krefting & Burwash, 1992).

⁴ References to patients and medical diagnoses seem most persistent in the United States where a large proportion of occupational therapists are dependent for third-party payment from health insurance companies which only fund work done with medical patients.

descriptions of people tend to begin something like 'this is a 38 year old schizophrenic patient', and descriptions of programs tend to start with something like 'the article describes a program for manic depressive patients'. In addition, occupational therapy's two main speciality areas are even identified using medical discourse: physical medicine and psychiatry⁵.

Furthermore, occupational therapy literature frequently refers to people as cases. The literature is full of references to cases, case studies, caseloads and numbers of cases studied. Yet cases are numbers or objects rather than active people. While showing awareness of the active concept of a client, occupational therapy literature has not yet articulated the contradiction in describing active people as cases (see analysis on 'case management' in Chapter 4).

3.4 Recognizing People's 'Active Power': Glimpses of the Ideal in Occupational Therapy Practice

The tensions evident in occupational therapy literature are carried into both the discourse and activities of actual practice. In Section 3.5, I present considerable evidence that occupational therapists participate in assessment and admission processes which conceptualize and categorize people as passive recipients of psychiatric treatment and the objects of management. However, from a standpoint within the everyday practice of transitional mental health programs, there are glimpses in which occupational therapists seem to conduct an ideal person-centred practice.

Glimpses of a person-centred practice are particularly apparent in the processes described as 'assessment' and 'admission'. Assessment in mental health services involves both discrete and ongoing processes in which mental health professionals gather information about people's mental state and social situation. 'Initial', 'intake', 'screening', 'preliminary' or 'pre-assessment'

⁵ 'Psychiatric practice' is now usually called 'mental health practice' as in the document "Occupational Therapy Guidelines for Client-Centred Mental Health Practice" (1992).

assessments tend to be discrete processes which occur prior to people attending programs. However, people may also begin to attend programs for a 'trial' period of a few weeks while an initial assessment occurs. Admission, i.e., official acceptance to attend programs, is dependent on professional assessment. Professionals interpret assessment information to decide whether or not people might benefit from attending programs. Assessment is also an ongoing process which provides information on people as they attend programs and determines how and when people will be discharged⁶.

When I reflected on my observation and interview data, I discovered four types of evidence which show actual practice to be somewhat consistent with an ideal person-centred practice. The four glimpses are that occupational therapists work with people in facilities and using time schedules which appear to expect that people will be active participants in programs; people are described as active 'clients' or 'members'; occupational therapists assess people's active participation in everyday life; and in their admission documentation in health records, occupational therapists write assessment summaries which describe active people living in communities. There even seems to be some institutional support for person-centred practice in that program brochures describe people as active participants in programs.

At the outset, it is important to note that occupational therapists in these programs are assessing people who have experienced mental difficulties which range from confusion and distorted feelings to outright delusions. Although some people's problems last a period of weeks or months, other people have had difficulty living in ordinary communities for years. They all experience difficulties which may include a short concentration span, tangential thinking, uncertain decision making, unpredictable emotional control, wide mood swings, high anxiety,

⁶ Examples of assessment and admission are provided throughout the analysis in this chapter. The ongoing assessment related to discharge is described in Chapter 8.

inability to organize personal hygiene and so on. Varying over time and between people, there are reports of people feeling lethargic, unmotivated, distracted, confused, disjointed, out of touch with reality, terrified, infuriated, elated or a host of other emotions⁷. The result of these difficulties is that people's power to act is distorted, suppressed or in other ways 'disordered'.

Nevertheless, the initial impression on entering transitional mental health programs is that people are conceptualized as having power to act. On entering the four programs which are in hospital settings (Sites B, C, P, R), one sees halls and rooms where assessment occurs typically in spaces designed to convey the belief that people have the potential to be active in these programs. Occupational therapy assessments, whether discrete or ongoing, involve observing people and asking them about their past and current potential to be active. Occupational therapists gather information as people cook in kitchens, talk with others in discussion rooms, water plants or do cleaning throughout the program area, complete clerical tasks in reception and office areas, do handcrafts or fix appliances in various types of workshops, have coffee in lounges, or otherwise demonstrate their power to act. The design of this type of space demonstrates recognition that people are active in contrast with other types of hospital space which typically consist of bedrooms observed by people in a control station. A person-centred recognition of active people is emphasized by the presence of posted schedules which outline morning and afternoon events from Monday to Friday. Schedules are posted with recognition that people have the autonomy and power to read and follow them. In these hospital settings, the street dress of staff and people contrasts dramatically with the staff uniforms and hospital gowns in other parts of the hospital where people do not stay overnight. In some hospital-based

⁷ This general summary of mental difficulties has been drawn from all sites from my observation of occupational therapists as they describe and document people's problems. The description has been supplemented from my past practice with people in mental health practice, and from psychiatric texts such as the *Modern Synopsis of Psychiatry* (Kaplan & Sadock, 1985).

programs, the contrast with typical hospital life is greatest where staff and people wear cooks' hats and aprons, mechanics' overalls, carpenters' aprons, exercise clothes or business outfits.

The other three programs I visited are located in old renovated houses (Sites J, M, N). From both the outside and inside, these houses resemble residences. Inside they look like homes in which people have established businesses. Except for one program where the space is mainly offices and group discussion rooms, the view on entering suggests a combination house, office building and workshop. With people scattered around the house, the kitchen, living room and bathroom are being used by what looks like a family dressed and acting to complete various ordinary life tasks. In some rooms, people are collating papers at tables, typing on computers, xeroxing, using sewing machines, packing boxes and various other activities typical of office work. Two of the three houses have a workshop with a table saw, drill press, anvil, wrenches and other tools. Tools are in various states of use as people are being assessed while building bird houses, fixing kitchen appliances, constructing Christmas tree ornaments and so on. Even more than in hospital-based programs, space seems to be designed with person-centred recognition that people have the autonomy and power to be active in shaping their lives.

In each program, one sees from about six to 30 people. In all but Site M, they are generally the same people each day. The occupational therapists, other professionals and the program secretary make up at least four of these people. The occupational therapist spends most of the day working with people in each of the areas. For instance, one day I observed Nora in the kitchen. As John walked in and said that he had some Polish recipes, Nora replied:

That would be great if you'd bring in a Polish recipe. We'd love to have a day of special recipes..when you're chef, you can cook us a Polish meal. [Nora looks over at Sue and John making cream soup for a lunch dish]..here, it's lumpy. You can use this whisk. [Nora then goes over the oven to take out muffins and speaks to Ted]..there, the oven is ready for your cake [turning back to Hal and Mack]...do you guys know how to take out muffins? Don't be afraid to go right around [Nora demonstrates how to use a knife then takes a sip of the cream soup]..mm this tastes wonderful..(Observation of Nora, NOB02, 304-330)

Nora is not providing service to waiting customers. She is working with people whom she recognizes as active in ordinary, everyday action. She conceptualizes them as active people with their own interests and history.

Second, not only do occupational therapists appear to be conceptualizing people as active, they refer to people as active 'clients' or 'consumers'. When I asked about this, therapists explained that they refer to clients/consumers to acknowledge that they are active participants. The most prominent recognition was in Site N which adheres to the 'clubhouse' philosophy in which people are recognized as active members (Anthony, Cohen & Cohen, 1983)⁵.

Third, a discourse conceptualizing people as active is incorporated into occupational therapists' categorization of people's active participation in daily life. This is particularly observable in the work of assessment. Occupational therapists' classic assessment question is: How would you describe a typical day?. Used over and over again in all sites, the question is directed to the present (today?, this week?, in the last month?) and the past (over the last year?, differences between this week and a year ago?). By asking when and where people are active, therapists discern the dynamic, temporal and spatial nature of people's participation in everyday life as autonomous active agents. These and other questions recognize that people have the power to be active in their daily lives despite their difficulties. In addition, questions invite people's participation as active investigators whose subjective knowledge, no matter how distorted or

⁵ The 'Clubhouse' philosophy is prominent in programs described as 'psychosocial rehabilitation'. One of its key assumptions is a person-centred recognition that people are active 'members'. Some psychosocial rehabilitation programs eliminate all professional involvement in favour of member control and operation of programs. Where professionals are included, professional recognition of members' power is a cornerstone of the professional-member relation. Site N has professional staff but strongly emphasizes the active power of members. Site J is the other program in this study which uses at least some of the ideas of psychosocial rehabilitation. Although Site J is not set up as a true 'clubhouse', the concept of an active person is emphasized as consistent with occupational therapy's own view of active persons. Psychosocial rehabilitation is also described with reference to decision making (see Chapter 5.4) and program activities (see Chapter 6.5).

frenzied, forms the basis for the assessment.

As assessment information is gathered, occupational therapists fit these 'facts' (see Chapter 2.5) about people's daily lives into categories defining active occupational performance. In each site, I heard occupational therapists ask people to describe their ability, interests in, beliefs about and other facets of their active performance in "self care", "productivity" and "leisure" (Canadian Association of Occupational Therapists, 1991, pp.16-18). These professional categories are actually used. For instance, occupational therapists typically ask people something like: How are you doing in self care?. However, if such categories are used, therapists tend to prompt people to think about being active in this segment of life, saying: By self care, I mean how often do you take a bath? Who does your laundry? and, Who gets you up in the morning? Similarly, occupational therapists ask people about their "environment" (pp.16-18). Then they explain something like: I am interested in knowing where you live and who you live with - generally how you live. It is rare for these questions to be asked all at one time in a formal interview. Although there may be an initial interview which raises some questions for 15 minutes to an hour, ongoing questions ask people how being active in the program compares with being active in their ordinary lives. Therefore, people are asked about being active but they are also engaged in action to observe how active they really are. In other words, occupational therapy's assessment process is person-centred since it develops a profile which recognizes people's power to act in everyday life. Occupational therapists highlight the 'occupational' facts about people's actual situations and their potential as persons who are actively engaged in shaping their lives.

An interesting facet of this work is occupational therapists' attempts to shift people's thinking away from their diagnostic symptoms and towards their power to act in real life. Pat's initial interview with Carl ('Ca') shows how this happens.

- Pat: It seems that last time you were here, you latched on to that diagnosis [post-traumatic syndrome]. Our concern in here is what are you going to do about it?
- Ca: I was ready to do something about it six months ago. But I only got the diagnosis three months after I was here.
- Pat: It seems very important to you to have that label. I know that's important to some people but other people just know their problems and try to do something about them without worrying what label they have. What's happening with your day besides work?
- Ca: I'm just at home part of the time. That's part of the problem. I'm not doing anything. I'm not very independent.
- Pat: How could you be more independent?
- Ca: I could be married, have kids, have my own place.
- Pat: Those are the big ones. What about day to day? For instance, who does the cooking at home?
(Observation of Pat, POB20P1, 172-197)

Pat listens to Carl's concern with his diagnosis but shifts the discussion from the diagnosis to his ability to express his 'active power' in everyday life. To do this, Pat refers to Carl's power to act as "independence" and makes the concept concrete by asking "What's happening with your day besides work?" As Carl continues to theorize about marriage, children and a home, Pat brings Carl back to concrete patterns, interests and ability by asking "What about day to day? She asks "Who does the cooking at home?" and "What is happening with your day besides work?". Pat later explained to me that she was asking about Carl's active involvement as well as his balance between self care, productivity and leisure. As her assessment proceeded after admission, Pat gathered more information around performance categories by observing Carl and asking about friends, work opportunities, social activities and other information. She recognizes Carl as an active person. But she is also educating Carl to think about himself as active. Through her assessment, she educates Carl to use occupational categories to demonstrate to himself that he is an active person with power to influence his own life.

On finding evidence that occupational therapists recognize active people and educate people to think about themselves as active, I turned to health records to see whether any documentary processes capture this person-centred feature. There I found a fourth indication that people's power to act is recognized to some extent in documentation. Comments on occupational performance are present in varying detail in health records in all sites. In all but Sites M and P, I found this information on forms called Occupational Therapy Assessment (or Progress). None of the forms exactly replicate all the categories from the Model of Occupational Performance, although I have seen such forms in other places in Canada. But they all use various headings related to these categories such as 'home management', 'personal care' or 'community situation'. The information has varying levels of analysis of people's performance and evidence of their active power to conduct their own lives.

Seeing that occupational therapy categories are present in some health records, I also looked at program brochures to see if my observations of assessment were consistent with the official discourse about these programs⁹. My general impression that people are recognized as active persons is supported by program descriptions in six sites¹⁰. Although the wording and formats differ, program descriptions convey a vision of people participating in programs. As

⁹ Descriptions have been developed by occupational therapists and other team members (sometimes with suggestions from people themselves) for publicizing programs and defining the criteria for access. For public relations purposes, they are posted on bulletin boards or information racks in program facilities, and they are used in public presentations such as mall displays during Mental Health Week. They convey to the public what the institution wishes the public to understand about transitional mental health programs. The other use of these materials is in the work of admission. They are circulated to agencies and professionals who might initiate a referral to have someone admitted to a specific program. They imply that programs recognize people as active and will admit those who agree to be active persons within the context of these programs.

¹⁰ The brochure reviewed from Site M describes what "the centre provides" in Direct Service, Consultation, and Education and Prevention. It does not refer to the expectation, described in the interview with 'May', that people will be active participants.

segments from these descriptions state, the staff will:

- ...enable you to live a healthy, productive life (Site B).
- ...assist you in making any changes you wish to make in your life (Site C)
- ...develop client's work skills (such as concentration, organization, responsibility) so as to train for job readiness (Site J)
- ...teach you the skills needed to function effectively and develop environmental resources needed to support and strengthen your present level of functioning (Site N).
- ...help people learn to cope with life problems in a constructive manner (Site P)
- ...enhance your functioning in this community (Site R)

These descriptions are the official discourse of programs. Although statements begin by indicating how staff will act, they also describe people as active program participants who live in a "community" with "life problems" and "environmental resources". People are cast as learners through references that staff will "assist", "enable" and "teach" and that people will develop "skills" and "function". The descriptions suggest that staff play a catalyst, educator role while people are recognized as having the potential to be active, at least to the extent that they agree to participate in these programs. Overall, people are recognized as active persons with the potential to learn to change themselves or their situation. As well, the public display of these materials seems to assume that people have the active power to read and learn about services on their own. These documents also make a public statement that people who attend these programs may have mental disorders but they are not passive recipients of care. Instead, the descriptions imply that people are recognized as having the autonomy and power to help themselves.

When I asked the occupational therapists in the study about working in these programs, they all commented that transitional mental health programs feel like they were made for occupational therapy. Therapists all said that they feel very much at home in these programs,

in part, because they are working with people who are recognized as having the power to be active in helping themselves. As well, some therapists pointed to expenditures in renovating hospital space or old houses as an indication of institutional recognition that the people who attend these programs have the power to be active. These are programs where face-to-face practice actually feels and looks like the type of person-centred approach considered ideal for enabling empowerment.

3.5 Transforming Persons into Patients and Cases: Undermining Practice

As I reviewed my observation, interview and documentary data on practice in each program, however, I began to see cracks in what appeared to be a person-centred practice. Carol shows how occupational therapists mix ideas of an active person with a discourse which conceptualizes and categorizes people as passive.

I always work from the point of view that the patient knows themselves best, better than I do, better than the psychiatrist does. Better than any of the other staff, they know what works for them, what's best for them...it's not for me to say 'oh, I think you can only work part-time - full time would be too much'. I...just kind of facilitate them looking at themselves (Interview with Carol, CINTOT02, 271-298)

Carol emphasizes her belief in people's active power. But in the same breath, she refers to people as patients. Throughout conversations, occupational therapists continually combine references to active people with a description of them as patients. Even when they refer to people as clients or members in general discussion, in formal meetings they shift references to patients. Almost without exception, people are described in official health records as patients. Throughout hospital-based programs, virtually everyone, staff and people themselves, refer to patients. The concept of a patient has been generalized so much that the title "No Longer Patient" (Sherwin, 1992) jolts us to reflect on societal assumptions that we will indeed be 'patient' about waiting for someone else to make us healthy.

Reliance on a patient discourse powerfully displays beliefs that people do not hold active power when it comes to their own health. Patients wait to be treated. They receive rather than participate in health services. Health professionals declare a moral responsibility to serve patients. In return, a patient's responsibility is to present a body and mind to be acted on by professional experts.

Although a philosophic critique of passivity in a discourse about patients could be considerably expanded, what is important in an institutional ethnography is analysis which displays how institutional processes organize action in the everyday world. In the examples which follow, we can see how the powerful ideology of a patient discourse organizes institutional processes and practices which categorize people as passive rather than active¹¹. Furthermore, a patient discourse educates people to think of themselves as passive recipients of medical care.

Despite evidence of a vision and practice which are person-centred, the institutional conceptualization of passive patients enters occupational therapy practice in subtle, seemingly innocent ways. Analysis of virtually every occupational therapy conversation displays this concept even where, like Carol's statement above, therapists are adamant that people are active. Even the most casual occupational therapy conversations can be seen to shape practice to fit the ideology of a passive patient.

Everyday discourse and activities are organized by ideological processes and practices but everyday discourse and activities also organize the ideological processes and practices within an institution (Smith, 1987) (see Chapter 2.5). An example of a casual comment by Rita shows how everyday practice is organized by and organizes (i.e., reproduces) the concept that people

¹¹ It is important to note that the ideology underlying a patient discourse not only negates the concept of an active person but has far reaching ramifications for all the features analyzed in this thesis. The ideology of a patient discourse individualizes practice and requires professionals to be dominant in deciding how best to provide specialized treatment and to protect patients from the risks of engaging in real, community life (see Chapters 4 to 8).

diagnosed with mental disorders are passive patients. She explains that her purpose in asking about people's typical day before they entered the program is to find out:

...what [a person's] life was like prior to the program and where we can see we might be able to make a difference. (Observation of Rita, ROB08, 115-118)

In saying "where we can see we might be able to make a difference", is Rita implying that it is now up to the therapist to determine what is best? The program may or may not make a difference. But if occupational therapy's concept of a person having active power was clear, might Rita have said "...and where we might guide a person to consider what changes he or she thinks are best"? The idea that people are passive is organized by historical and contemporary medical practices. Rita, like occupational therapists in general, reproduces these ideas through everyday speech.

In other words, the cracks become visible in what seem like unimportant nuances of speech. These nuances, repeated over and over, show the power of long held ideas that patients are passive. These ideas underpin assumptions that ill people have somehow lost their agency, their power, and their knowledge to decide what is best for themselves. However, more than assumptions, these ideas underpin processes of medical diagnosis in which ill people are conceptualized as passive patients. Mental disorders do distort thinking and rob people of their power to understand themselves and the world. Yet, except where there is severe psychotic illness, people retain some degree of active power to influence everyday life.

The concept that persons are patients appears to shape the whole health system towards assumptions that people are not active agents. A patient discourse blatantly contradicts any recognition of people's active power in the design of facilities or in program descriptions. Although occupational therapy believes that people have active power, references to patients convey that, in a health context, occupational therapy conceptualizes people as passive.

Beyond reproducing seemingly innocent nuances of speech, occupational therapy actually

contributes to the categorization of active people as passive patients. Occupational therapists contribute to such categorization because they transform their reports of people's actual lives into evidence of pathology. In Section 3.4, I showed Pat shifting Carl's attention from his psychiatric diagnosis to her categorization of everyday life. However, there are far more instances in which the process occurs in reverse. Facts about active persons participating in everyday life are transformed into facts for categorizing patients using medical (psychiatric) problems and diagnoses¹². As I observed and reviewed documents, it became clear that the transformation occurs during the official discussions and documentary processes of assessment and admission. Carol's ('Car') description to me ('et') shows the twist in which information displaying people's active power is translated into an interpretation of mental pathology.

et: Daily schedule - what would you do with that? What would you be looking for?

Car: I guess you can find out a lot of information by posing the question 'describe a typical day'. I use that a lot because I get a lot of information.

et: What do you pick up - what kind of information?

Car: ... What their level of activity is - if they're depressed, and if they're manic - if they're feeling abused, threatened - if they're compulsive housekeepers - that kind of thing - what their sleep patterns are - that's important as well. And this gives you a really good idea of how they are functioning before [attending the program]. (Interview with Carol, CINTOT01, 735-758)

Or as Rita explains while looking at a weekly schedule sheet just completed by a woman who is very concerned with her medication:

Most people don't put in that they take their medication. So, in fact, this is very interesting to see, well number one, that she does take it as prescribed. But it seems to be a very important part of her life that she would even write it down on the page. (Observation of Rita, ROB08, 474-481)

¹² See Chapter 2.5 for a description of the organization of facts into objectified knowledge for use in objectified management.

The assessment questions which Pat poses to Carl (in Section 3.4) organize people's everyday life information into occupational categories. However, Carol and Rita's comments, above, describe how occupational therapists use this information as a medium for interpreting the mental disturbance and medical treatment of a patient. The information has face-to-face value in enhancing people's knowledge about themselves. But its primary purpose is to divine patients' mental states. Interpretations of mental disorder are reported at 'intake meetings', 'assessment meetings', 'case coordination meetings' or 'rounds'. These are official meetings in which professionals discuss what they have learned about people before and after admission. Although occupational therapists' casual conversations include references to active clients and members and to categories which recognize that people are active in everyday life, the majority of talk and action in official meetings shifts this information into the ideological concepts and categories used to describe a passive patient. In other words, the ideal occurs but is transformed.

To see how the transformation from an active person to a passive patient occurs in documentation, I looked at health records beyond occupational therapy's assessment and progress reports. Occupational therapy reports, like those used by other professions, are included as part of health records. However, they simply provide the background data for the psychiatric assessment. In all sites, it is the identification of psychiatric problems or diagnoses, not the assessment (and categorization) of difficulties in everyday occupations, which determines access to transitional mental health programs. In day-to-day practice, occupational therapists and others use a variety of assessment information to decide whether or not someone will be admitted to a program. But, in the end, their decisions are guided by management policies which require documentation of a medical problem or diagnosis, based on the categories of the DSM-III-R¹³.

¹³ Psychiatry uses the internationally recognized categories of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (American Psychiatric Association, 1987). The DSM parallels the International Classification of Diseases (ICD) developed and used by medicine to

Certainly, it makes sense that physicians diagnoses patients: medical processes of diagnosis and treatment of pathology do not require an active conception and categorization of people¹⁴. However, medical diagnoses conceptualize people as passive. As well, each diagnosis defines only a fragment of human experience rather than the full contextual experience of an active person. Mental disorders are real and need medical attention. But medical categorization is the only categorization which qualifies people for official admission to mental health services.

Although occupational therapists' references to patients and medical diagnostic categories may seem inconsequential, the consequence is that occupational therapy's potential to develop a person-centred practice is seriously undermined. Person-centred practice is undermined as occupational therapists contribute to the transformation of active people into passive patients.

Furthermore, being categorized as a diagnosis educates people to think of themselves as disordered objects described as schizophrenics or manic depressives. As we saw in the exchange between Pat and Carl, occupational therapists have an uphill struggle to encourage people in these programs to think of themselves as anything but passive medical objects. Occupational therapists'

classify the aetiology (cause) of diseases, including neurological diseases associated with mental disorders (World Health Organization, 1984). The DSM was developed to integrate organic and psychopathology with social conditions into the newer concept of "mental disorder". I acknowledge the ideological character of the DSM, particularly in interpreting gender (Chesler, 1972; Howell & Bayes, 1981; Ingleby, 1981; Smith and David, 1975). However, its integration of psychological and social elements of life is less fragmenting and has more social analysis than other medical categorizations (Shepherd, 1985). A feature of DSM which distinguishes it from other medical classifications is its accommodation of psychological and social concepts of function in a system of multiple axes. Occupational therapists have lauded the addition of the most recent axis, Axis V, which integrates everyday dysfunction and function in the classification (Canadian Association of Occupational Therapists, 1994). However, none of the seven occupational therapists organized the formal 7 day observation or documentation of daily life required for an Axis V diagnosis. In Site M, access is not determined by a medical diagnosis or psychiatric signature. However, people are still categorized for institutional statistics using a 'problem' list which uses the categories of the DSM-III-R.

¹⁴ I note that the better physicians personally recognize active people by drawing them into the processes of assessing and monitoring their health. However, this interpersonal recognition differs from the institutional categorization of diagnoses.

attempts to inject ideas that patients are active are limited to educating people to contribute to medical interpretations of their life experience. Medical interpretations of life pervade the way of thinking in these programs so that people say things like:

I think I've got to change my personality. (A person in Site P, POB12P1, 459-460)

Or as another person in a group with Rita exclaimed one day:

I had a brain wave on the way over here today. What do you think of this? I think that I'm not really depressed. That diagnosis doesn't really fit. I think I'm actually hyper-stressed! (A person in Site R, ROB10, 364-369)

On seeing how occupational therapists' person-centred practice is undermined by official assessment and admission processes which fragment active people into passive medical patients, I also began to see how objectified management operates in actual practice (see Chapter 2.5). Facts about people's actual lives are collected by occupational therapists and other professionals. From the full narrative of people's lives, facts which are relevant to diagnostic categories of mental disorder are then selected. The textual classification of mental disorders means that people can be categorized as a psychiatric problem or diagnosis whether or not a psychiatrist is actually present. The problem or diagnosis must be entered on official records. Then, the diagnostic category is used to coordinate assessment information from various mental health professionals and to control program admission, again, whether or not a psychiatrist is actually present.

In actual practice, occupational therapists, like other professionals, may conceptualize and categorize people as active persons. In doing so, occupational therapists exercise considerable judgement in assessing whether people might benefit from admission to programs. As well, people often become involved in program activities long before the official diagnostic confirmation appears on a health record. However, as Bev says, in the absence of the psychiatrist, the practice is to "make a little note to our Medical Director".

Whose ever turn it is gets the chart as soon as possible looks at the chart, interviews whoever made the referral, and, if they feel the patient is appropriate - or even if they don't actually - they make a little note to our Medical Director saying 'we feel this patient is appropriate or not for whatever reasons' - and he says what he thinks. So we review it, give our opinion, then the Medical Director looks at it. Generally, if we think they're appropriate, it's just a rubber stamp. We have rounds every Thursday afternoon -and if we disagree on whether a patient should be admitted or not -then we talk about it. (Interview with Bev, BINTOT01, 616 - 634)

I emphasize that occupational therapists' contributions to assessment and admission work processes are not coordinated and controlled through face-to-face interaction with psychiatrists. Instead, these processes are coordinated and controlled by the largely documentary practice of conceptualizing and categorizing people as DSM-III-R categories. Therefore, occupational therapists, like other professionals, are required to translate and justify their assessment of active people using concepts and categories which define people as medical patients.

In addition, people are managed as cases which are categorized by psychiatric diagnoses. As a result, active people are not only fragmented by their diagnostic categorization. They are also objectified as cases relevant to the objectified management (see Section 2.5) of mental health services. The implication is that occupational therapy's possibilities for developing a person-centred practice are largely submerged by the assessment process of diagnosing a psychiatric patient and by the management process of admitting and managing only those cases which are categorized as psychiatric patients¹⁵.

Moreover, provincial occupational therapy legislation generally requires occupational

¹⁵ The ideological processes of managing an object defined as a 'case' are analyzed with reference to individual case management. Subsequent analyses illustrate how cases are engaged largely in individual action (see Chapter 4), controlled decision making (see Chapter 5), education which simulates real life (see Chapter 6), processes of change which protect cases from risk taking (see Chapter 7) and processes which perpetuate the stigmatization and marginalization of psychiatric cases (see Chapter 8).

therapists to work under the supervision of a physician¹⁶. Such legislation favours occupational therapists' employment in medically-organized settings and undermines occupational therapy's commitment to work with active people. Furthermore, as subsequent chapters show, occupational therapy is largely accountable for managing medically-diagnosed cases within the boundaries of medically-organized facilities.

3.6 Summary

Glimpses of an ideal person-centred practice exist in occupational therapy's recognition of active people. In occupational therapy literature, people are conceptualized as active clients and categorized with recognition of their power to be active in the broad ranging occupations of life. In actual practice in transitional mental health programs, occupational therapy's conceptualization of active people is somewhat retained. Even programs in hospital settings expect people to appear in ordinary street and work clothes rather than hospital gowns. Facilities are designed for people to participate in activities rather than to wait for hospital tests or treatment. In particular, occupational therapists assess people by recognizing their subjective knowledge of their own lives and by organizing information about everyday life into 'occupational' categories which acknowledge that people have the power to perform in the occupations of life. There are even glimpses of a person-centred practice in occupational therapists' assessment reports and in the descriptions of active people in program brochures. As a rule, people are encouraged to think about themselves as active persons in defining and controlling their own health.

¹⁶ In the four Atlantic Provinces, only occupational therapists in Prince Edward Island have legislation which allows them to work without a medical referral. Although other provinces are currently attempting to remove this medical restriction, Prince Edward Island's legislation remains an exception to typical legislation governing occupational therapy in most Canadian provinces and countries.

However, tensions surround this feature. Glimpses of person-centred practice are undermined even in the interpersonal realm of day-to-day interaction where people are often described as patients defined by diagnostic categories. Moreover, in the official realm of health services, occupational therapy's conceptualization and categorization of active people is officially submerged. Submersion is particularly clear in the work of assessment and admission. In these processes, active people are officially conceptualized and categorized as psychiatric patients and cases. The transformation of active people into psychiatric patients is so complete that people themselves and the public refer to people as patients once they have been diagnosed even if they are no longer in a medical institution or undergoing medical treatment. By contributing to the medical diagnoses of patients, occupational therapy also contributes to the categorization of the psychiatric cases managed by mental health services. Therefore, occupational therapy engages in processes which 'passify' active people.

CHAPTER 4

INDIVIDUALIZING ACTION

4.1 Introduction

The analysis in Chapter 4 builds on Chapter 3. Here, I examine a second core feature in an ideal empowerment-oriented practice: *recognizing the interdependence of individual and social action* in the world. A synthesis of literature outside occupational therapy indicates that interdependence is recognized where practice enables people to connect individual and social (i.e., environmental¹) action. Both possibilities and constraints for developing this feature appear in occupational therapy literature and practice. There are glimpses of possibility where occupational therapy enables people to connect individual with social action. Yet actual practice is almost overwhelmingly focused on enabling individual action. Tensions surrounding this feature are analyzed by examining the 'goal setting' and 'case coordination' processes of 'individual case management'. The analysis shows how the emphasis on enabling individual versus social action in a practice is largely organized by the types of data (i.e., the 'facts') used by institutions to manage the quality and efficiency of practice.

¹ The term 'social' rather than 'environmental' change will be used throughout the thesis. Practices oriented to social change address the environment but the phrase "social change" is more commonly used in literature on empowerment. Furthermore, the term "environment" is often narrowed to its physical dimensions such as air, land and water. Occupational therapy uses the term "environment" broadly to include social and cultural as well as physical elements (Canadian Association of Occupational Therapists, 1991). Interest in the physical environment is focused on the organization of space, such as wide doorways and braille signs, to make home and community spaces accessible to people with physical disabilities. In recent years, occupational therapy has made explicit its interest in economic, political and legal elements of the environment (Law, 1991).

4.2 Connecting Individual and Social Action: An Ideal Practice

Building on the fundamental belief that people have power to be active, an ideal empowerment-oriented practice recognizes that people's actions are interdependent. This means that people's power to act is not an object which grows in a vacuum. People's power to act is shaped within a social context. Both individual and social action are interdependent².

Here, individual action refers to action taken by individuals to enhance their personal development. Social action refers to action taken by individuals or groups (i.e., collective social action) to shape the local and broad social context of life. In the local social context, individual and social action are both shaped through connections with family, friends, neighbours and the people who operate local businesses, community support agencies and so on. However, individual and social action are also shaped through connections with institutional and other broad social practices. Philosophies, policies, procedures, financial resources, legislation which organize social functions such as health services also shape individual and social action (see Chapter 2.5).

Overall, then, individual and social action are shaped through connections with the local and broad social context. But social action shapes and is shaped by the local and broad social context. Moreover, individual action to enhance personal development provides an underpinning for people to engage in social action. Therefore, there are complex multifaceted interconnections which produce the interdependence of individual and social action. To recognize interdependence, an ideal empowerment-oriented practice connects individual and social action in both the local and broad social context.

² As subsequent chapters incorporate other core features in an ideal empowerment-oriented practice, individual and social action are analyzed with reference to decision making (Chapter 5), the simulated versus real nature of action (Chapter 6), the risk taking associated with action oriented to producing transformative change (Chapter 7), and the ethical commitment required so that action promotes inclusiveness (Chapter 8).

To recognize interdependence, one emphasis in an ideal practice is on enabling individual action which enhances people's individual development of "personal empowerment" (Lord & McKillop-Farlow, 1990). This means that individuals are guided through actions oriented to producing an inner transformation of their perception of being powerless (Adamson, 1990; Brookfield, 1987a; Lord & McKillop-Farlow, 1990; McLelland, 1975; Mezirow, 1978; Mezirow & Associates, 1990; Zimmerman & Rappaport, 1988). In an ideal practice, individuals are guided to think about themselves as powerful entities with an internal locus of control which can be exerted in the actions associated with decision making, choice and leadership (Lord & McKillop-Farlow, 1990; Zimmerman, 1990; Zimmerman & Rappaport, 1988). An ideal practice also recognizes that, for some people, the focus is on a spiritual transformation which empowers individuals to perceive the power of their individual actions and their connection to a spiritual force beyond themselves (Adamson, 1990).

Incorporated with this work of enabling people to transform their perspective on power, an ideal practice enables "personal empowerment" by coaching individuals to develop the behaviour required to perform the instrumental functions required for everyday living (Checkoway & Norsman, 1986; Rose & Black, 1985; Sutcliffe, 1990; Zimmerman & Rappaport, 1988). Practice coaches people in the skills and knowledge to look after themselves, find employment, manage money and shopping, organize transportation, decide priorities, solve problems in everyday situations, and so on.

To recognize interdependence, however, the other important emphasis is on enabling local and broad social action. In an ideal practice, there is recognition that the potential for people to exercise power is organized in a social context which is partially created by the people and material conditions which constitute everyday life. Therefore, on a local scale, an ideal practice enables individuals and groups to engage in social action to shape friendships, family, home,

work or various community situations. In doing so, an ideal practice supports social action to develop natural forms of helping such as self help and mutual aid (Baker, 1977). Such a practice also enables social action to develop social networks and other local forms of social support for everyday living (Gottlieb & Coppard, 1987; Stewart, 1992). To facilitate local social action, practice may enable people to seek support for their empowerment from mediating structures such as churches and volunteer groups (Berger & Neuhaus, 1977).

Furthermore, an ideal practice enables individuals and groups to integrate local social action with the collective social action required to remove institutional barriers to their empowerment (Freire, 1973; Kilian, 1988; Kuyek, 1990; Lesemann, 1984; Pinderhughes, 1983). Therefore, an ideal empowerment-oriented practice is critically informed (Fay, 1987; Freire, 1972; Habermas, 1973). In a critically-informed practice, practitioners are involved in social action and enable people to engage in collective social action. In some instances, practitioners may engage in social action on behalf of people since practitioners may be in positions of authority where they can design institutional processes to support people's empowerment³. Such activism does not directly enable people's empowerment. However, it helps to develop social conditions which support rather than undermine people's empowerment. However, the work of enabling people to become empowered is that of engaging in social action with people. Moreover, an ideal practice decreases practitioner involvement as the need for social action diminishes or people learn to proceed on their own. In any case, the aim of broad social action is to develop institutional philosophies, policies, procedures, financial resources and legislation based on an ethical commitment to support the empowerment of those not empowered (Giddens, 1984; MacIntyre, 1984). In essence, an ideal practice enables broad social action with awareness

³ In Chapter 5, the significance of distinguishing whether work is conducted with or on behalf of people is clarified with reference to an ideal practice in which there is collaborative decision making.

that historical practices of governing have meant that some social groups (such as professionals) have controlled others (such as patients) (Illich, Zola, McNight, Caplan & Shaiken, 1977; Smith, 1987; Young, 1987; Zola, 1984).

Moreover, an ideal empowerment-oriented practice emphasizes the interconnectedness of individual and social action (Brookfield, 1987b; Leighton, 1982; Smith, 1990b; Veatch, 1990). There is recognition that individuals are not solely responsible for initiating and taking action to reduce their powerlessness (Foucault, 1972; Grace, 1991; Marantz, 1990; McLeroy, Gottlieb & Burdine, 1987; Ryan, 1976; Whitmore & Kerans, 1988; Zacharakis-Jutz, 1988). Conversely, there is also recognition that individuals' perceptions of powerlessness and lack of competence influence their potential to engage in individual and social action (Ellsworth, 1989; Steinem, 1993). Therefore, an ideal practice builds on examples of the interconnectedness of individual and social action drawn from the experiences of civil rights, feminist and other 'rights' movements (Bachrach, 1977; Cook, 1988; Checkoway and Norsman, 1986; Dill, 1987; Felton & Shinn, 1981; Labonte, 1991; Ng, 1984; Rose & Black, 1985; Steinem, 1993; Young, 1990).

4.3 Emphasizing Individual over Social Action: Occupational Therapy Literature

Based on its philosophy and history, occupational therapy appears to have considerable potential to develop an ideal practice in which individual and social action are guided as interconnected processes and practices. Occupational therapy has an activist philosophy and heritage of connecting social with individual action (Frank, 1992). However, tensions surround development of this feature since individual action is emphasized so much that the work of enabling social action has remained marginal within occupational therapy. As well, much of occupational therapy's social activism has tended to be more on behalf of than with people.

Although the work of enabling people to engage in social action has never been dominant

in occupational therapy, there are historical and current examples (Johnson & Yerxa, 1989; LeVesconte, 1935). Historically, descriptions of occupational therapy practice outside health facilities show some involvement with individuals and groups who are engaged in social action to change homes, schools, work places, training centres, shopping and banking, transportation, communication and virtually every other area of daily life (Grady, 1992).

In addition, from occupational therapy's early days at the turn of this century as a profession for upper class women (see Chapter 1.4 and 1.5), therapists have used their financial and political connections to develop community resources, special needs programs, financial support services, legislation and other social practices on behalf of people with disabilities. On behalf of these people, occupational therapists have engaged in local and broad social action by becoming members of Boards of Directors, government committees, management planning groups, legislative groups or even lobby groups oriented to structuring society beyond local situations (Frank, 1992; Hamlin, 1992). The literature even offers a few examples of occupational therapists working to change national and international limitations for people with various types of disability (Krefting, 1992).

Since the 1980's, occupational therapy has re-emphasized its interest in social action by focusing on the environment (defined in Footnote 1, p. 69) as a site for practice (Law, 1991). There is an interest in including social action beyond occupational therapy's work with individuals. For instance, drawing on Foucault and Navarro, Kielhofner has begun to urge occupational therapists to engage in social action to change "social structures" described as the resources and services in communities. His approach to addressing social action is to urge occupational therapists to engage in a "dialectical evaluation" of the person and "environment" and to practice in ways which make the "social collective good for individuals" [my emphasis] (Kielhofner, 1993, p. 251).

While this re-emphasized interest in the environment tends to perpetuate the approach of taking social action on behalf of people, a few occupational therapists are emphasizing social action with people. Some occupational therapists are advocating that practice include social action to address 'interdependence' rather than independence (Kari & Michels, 1991; Kinebanian & Stomph, 1992; Meyers, 1992). Social action is encouraged with seniors and others who are developing self-help groups and independent living centres (Canadian Association of Occupational Therapists, 1993c). In encouraging occupational therapists to enable people's involvement in social action, there is growing awareness of power and powerlessness associated with culture or race (Dillard, Andonian, Flores, Lai, MacRae & Shakir, 1992; Dyck, 1992) and gender (Pierce & Frank, 1992; Pizzi, 1992; Primeau, 1992). In Canada, Jongbloed and Crichton stand out in advocating a socio-political practice for and with people with disabilities. They advocate that occupational therapists work with people to revise legislation such as the Vocational Rehabilitation of Disabled Persons Act and the Canada Assistance Plan (Jongbloed & Crichton, 1990).

To some extent, occupational therapy involvement in social action on behalf of people seems to contribute to tensions in connecting individual and social change. Occupational therapists' involvement in social activism appears to have given those within the profession the sense that social action is part of practice. However, occupational therapists appear to have developed only limited awareness that the work of enabling empowerment requires them to engage people themselves in social action.

Nevertheless, there are even greater tensions which limit the development of this feature to be more consistent with an ideal empowerment-oriented practice. By far the greatest proportion of occupational therapy's work has been and is devoted to enabling individual action. Occupational therapy is highly grounded in 19th and 20th century visions of individual personal

development. Individualism has shaped much of occupational therapy's stated philosophy (Kielhofner, 1985a, 1992; Mosey, 1981; Reed, 1984). For instance, Canada's generic Model of Occupational Performance focuses on individual performance even though there is recognition that individual action is shaped by an environment (Canadian Association of Occupational Therapists, 1991). Occupational therapy literature shows an almost total grounding in Maslow's, Piaget's and other individualistically-oriented theories of human development (Banus, 1979; Fidler & Fidler, 1978; Llorens, 1970; Mosey, 1970). A huge proportion of occupational therapy literature describes programs designed to enable individuals to enhance skills which have been lost or never developed. For instance, program descriptions and research are predominantly directed at individuals' cognitive and emotional growth in the face of perceptual, developmental, physiological, social, cultural or other limitations.

4.4 Highlighting Instances of Social Action: Glimpses of the Ideal in Occupational Therapy Practice

The analysis of occupational therapy literature shows tensions in which a highly individualized practice overshadows glimpses of therapists engaging in and even enabling social action. These tensions are also present in actual practice (see Section 4.5). However, the data provide glimpses which suggest that all seven occupational therapists in the study somewhat recognize the interdependence of the people who attend transitional mental health programs. For example, in their discourse about the environment, these occupational therapists seem aware of the importance of the social context of people's lives. All seven occupational therapists describe examples of enabling people to engage in some local and broad social action although this tends to be on behalf of more than with people. As well, the structure of program facilities and schedules suggests that occupational therapy is managed with the assumption that this practice,

like other professional practices in transitional mental health programs, combines individual and social action. Moreover, occupational therapy position descriptions can be interpreted to support social as well as individual action with the people who attend these programs.

When I began to ask occupational therapists to describe the range of activities in their work, they all highlighted their commitment to enabling social as well as individual action. Included in their descriptions were many examples of enabling individuals to enhance their personal development (see Section 4.5). However, they all emphasized their involvement with community groups and services as going beyond official expectations for working in hospitals with individuals.

The seven occupational therapists all displayed some awareness of the social context of life by referring to occupational therapy's conceptual framework and long standing involvement in structuring the environment. For instance, Nora describes the importance of attending to a "person-environment fit":

I hope I'm not giving the impression that I think that it's strictly individual - because you have to understand the whole environment - and that's again a key of occupational therapy - the environment, the person-environment fit, and working with that - their whole kind of social milieu - understanding its impact and - there is sometimes a point where it isn't always the person. (Interview with Nora, NINTOT03, 481-492)

Nora describes her involvement in social action in terms of "working with...their whole kind of social milieu". In this statement, she seems particularly interested in making clear her recognition that "it isn't always the person".

This commitment to changing the environment seems to be accompanied by some actual involvement in enabling people to engage in local social action organized as part of the actual program (more fully described in Chapter 6.4). For instance, occupational therapists enable people to engage in social action which shapes the day-to-day events within programs. Every program includes sessions where people engage in the social action of planning the day and future

events for the program beyond their own plans for individual action. In Site C, this is called the Morning Meeting; in Site P, the Warm-up Group; in Site N, the Check-in Meeting. Sites B, J and R each have a weekly planning meeting. Site M does not include the same people all day so omits this event. Moreover, in each site with varying frequency, planning shifts away from daily or weekly activities to address the social context beyond programs. During this type of discussion, people talk about barriers and ideas for changing transportation, sheltered employment or subsidized housing. As these topics arise, people describe problems or solutions associated with using buses or finding a place to work and live. During discussions, occupational therapists seem to encourage people to talk about municipal, provincial or national issues. Occasionally, occupational therapists urge people to get together to send a letter, join a local march, call politicians and managers to get information, negotiate with hospital managers for 'patient' rights and privileges, write proposals to get funding for recreation, employment or housing, or otherwise engage in various types of social action.

In Sites P and R, where observation extended over eight and six weeks respectively, I observed the occupational therapist engaging in social action with people, i.e., enabling people themselves to engage in social action. Pat and Rita both worked with at least one or two people in some type of social action every few days to resolve a personal or local community situation. In the other five sites, I either observed or heard occupational therapists describe some ongoing work in which individuals or a few people are guided in local social action. For instance, Nora describes a large amount of work through which she involves program members in community issues. Within programs, she involves people in writing briefs, preparing speeches for community events and developing public relations materials. She is also engaged in developing transitional employment options such as supported employment (Interview with Nora, NINTOT03, 593-600). May, too, has considerable involvement in social action. When I asked

her about social action, she immediately replied:

One of the first things I got involved in [was] the transition house association. I got asked to help - it was initially just a general meeting. Anyone interested in the community with getting something organized that was going to be a help to victims of violence. Specifically, we were talking about women and children. And, there was already an idea to have a shelter. That had been discussed before - so that was their main focus. So I got involved in that at a general meeting. Then I joined the Board. Then I was on the Board of Directors for a couple of years. And since then, I've been involved with them from time to time, certainly as a referral source. And also, at times, doing sessions, seminars with some of the women. (Interview with May, MINTOTO1, 765-788)

In another example, Pat describes her involvement in developing a new group home:

I meet with them once a week. And what I do with them once a week has really varied. When all three of them were new to the house, I spent a lot of time doing meal preparation and stuff, budgeting, we did up a household cleaning schedule, those kinds of things. And over the last couple of months, there's been a lot of interpersonal problems and I've gone in there and we've basically had a group therapy session for an hour with all of them. I mean their concerns, gripes, and calling each other names. (Interview with Pat, PINTOT03, 371-388)

In addition, the occupational therapists in this study all described involvement in social action on behalf of people. They are all involved outside program facilities where they are members of committees, groups, volunteer Boards of Directors and various organizations advocating for and participating in the development of transportation, housing, employment, recreation and other aspects of community life. Bev and Rita listed social action in their involvement in developing special programs through the YMCA to address problems faced by people living in the community with mental disorders. Bev has also been assisting with the development of a sheltered workshop for mentally handicapped people, and an extended care nursing home for people with mental handicaps. Carol is participating on various community committees and a task force examining the reorganization of provincial mental health services.

In exploring social action with Jill, I asked:

et: Is it fair to say that your advocacy is primarily with the individual, and that you're not really involved in broader social action?

Jill: No - both. I was quite active in this Employment Incentive Committee a couple of years ago. And that was a bunch of us - all the organizations from the community...as well as people from the hospital. And we were lobbying the government to change that whole system...the occupational therapy director is very supportive of us - always wanting an occupational therapist to be on these community-based committees - so that we can give our input. I think there are a number of other committees. But that is the one that I was involved with. And the housing program that I'm involved in. I have a lot of say in that. That's all community-based. (Interview with Jill, JINTOT01, 1665-1693)

When I followed up by asking how people were involved in the Employment Incentive Committee, she replied:

That's a fairly political group - and a lot of that was based on client comments and case histories from clients. So that was the way they were involved. (Interview with Jill, JINTOT01, 1703-1710)

These examples indicate that occupational therapists are aware of the importance of connecting social action with their work with individuals. Examples of working with people (as in collaborative decision making in Chapter 5) illustrate how occupational therapists actually follow through on their commitment to social action. Certainly, these examples indicate that occupational therapists enable people to engage in local social action to reduce local barriers to people's empowerment - barriers such as the lack of group homes and transition houses. However, the examples of broad social action refer more frequently to occupational therapists' own social action. There is some evidence that occupational therapists enable people to become involved, while the greater evidence shows that they are more likely to engage in social action, such as committee work, on behalf of people.

As I reflected on occupational therapists' involvement in social action with and on behalf of people, I realized that there is some official expectation for occupational therapists to include some social action as part of practice. Program facilities (space) and schedules (time) are

structured to make it possible to include both individual and social action⁴.

In program facilities, the group rooms in each site provide recognition that collective action is expected to occur within the program. Office space for meeting with individuals is at least equalled or surpassed by space for working collectively with people. Each program includes at least one room called a Group Room with chairs and sofas arranged in a circle for collective group discussion and planning. As well, five of the seven sites (excluding Sites M and R), have a kitchen, workshop, and general work room which are used to work with people collectively as well as individually. In addition, all programs have some type of lounge in which people meet collectively without professionals during coffee breaks and between scheduled activities. The design of facilities suggests that occupational therapists are expected to guide people through the initial steps of becoming involved in social action from within the program.

Involvement in social as well as individual action has some institutional support in the scheduled structure of time in these programs. The typical day includes individual time and at least two types of collective (group) events. My estimate from analyzing schedules and observing over a number of weeks is that occupational therapists spend at least 35% of their time working with people collectively and 35% with individuals and their immediate social contact persons. Overall, then, approximately 70% of occupational therapists' time is spent in face-to-face contact, planning, telephoning, team meetings and making arrangements. As well, 10% of time (sometimes more and sometimes none in any week) is spent in social action sometimes with and sometimes on behalf of people. The other 20% of occupational therapists' time is spent in meetings and documentation which may refer to individual or social action or both.

⁴ In Chapter 3, I described some elements of facilities and schedules to show that people's power to act in life is recognized. In Chapter 6, the structure of program facilities (space) and schedules (time) will be more fully analyzed with reference to the simulated versus real life orientation of programs.

In addition, there is sketchy evidence in occupational therapists' position descriptions that mental health services management expects occupational therapy to include some social as well as individual action. Rita's "Position Description" lists a typical array of duties as displayed in Table 1.

Table 1	
Occupational Therapist: Position Description (Site R)*	
List of Duties:	
Upon referral the occupational therapist shall:	
<ul style="list-style-type: none"> - evaluate the patient's condition and level of function, through the use of interview, observation, or assessment - determine treatment goals, discussing these with the patient and informing them of the nature and risks of treatment - implement appropriate treatment programmes using dyadic or group intervention - progress, adjust, and terminate programmes ensuring appropriate referral and follow-up where indicated - assess the effectiveness of treatment programmes - refer patient to other therapeutic services in the department, hospital, or community - record method and results of evaluation; programme goals and outcome; disposition of the patient - contribute to the clinical team by participating in the process of diagnosis, goal development and patient management; and by the regular contribution of clinical observations 	
The occupational therapist shall also:	
<ul style="list-style-type: none"> - participate in determining the philosophy, objectives, and policies of the department - participate in the evaluation of own performance and that of others under his direction - participate in and contribute to programmes of staff education and orientation - maintain necessary records, reports, and statistical data - supervise auxiliary staff or students as directed - promote and practise good interpersonal and interdepartmental relationships - assist in the administration of the department when requested - make effective use of supplies, equipment, and facilities - assist with all departmental programmes as directed - perform other related duties 	
* Reproduced from actual document without location identifiers.	

Of particular interest are the two statements which I have highlighted in bold type. One statement is "implement appropriate treatment programs using dyadic or group intervention". This

statement offers possibilities for engaging people in collective action even though groups are largely used for social learning. As well, the position description states that occupational therapists "participate in determining the philosophy, objectives, and policies of the department." This statement too offers possibilities. It supports occupational therapists' involvement in shaping institutional processes. But, it also offers a window for occupational therapists to involve the people who attend transitional mental health programs in developing some aspects of the program philosophy, objectives, and policies. Although the evidence of institutional support is weak, these statements create possibilities for enabling people to engage in some local and broad social action.

Also weak but nonetheless existing is evidence that management supports occupational therapy's own involvement in social action by sanctioning use of The Canadian Workload Measurement System: Occupational Therapists (WMS) (Campbell, 1980; Statistics Canada, 1979). The system is strongly oriented to documenting time spent in enabling individual action. "Direct patient care" and "indirect patient care" are documented in five minute time units attributed to individuals on time unit records, even if people are engaged collectively in various sizes of groups. However, one section of "non-patient care activities", i.e., time not allocated to individuals, lists "service to community" including "board/community function", "public education", "consultation" and "service to profession". Where people are involved in social action, the time for this type of practice can be recorded⁵.

As the next section shows, practice is highly individualized. Nevertheless, occupational therapists' commitment to and involvement in social action demonstrate recognition of the

⁵ My memory of the development of the WMS in the 1970's is that this "non-patient activities" category was inserted in response to strong representation by occupational therapists to Health and Welfare Canada and Statistics Canada. The WMS was developed for use by both physiotherapy and occupational therapy since these were seen as highly similar practices. Occupational therapists argued that the system needed to acknowledge occupational therapy's historical involvement in social as well as individual action.

interdependence of individual and social action. Most prominent are examples of social action on behalf of people, although, in all sites, there are examples of occupational therapists engaging people in local social action consistent with an ideal practice.

4.5 Individualizing Goal Setting, Coordination and Documentation: Narrowing Practice

Although there are glimpses which highlight the presence of social action on behalf of people and sometimes with people, the emphasis is strongly on enabling individual action to address personal problems and goals. Yet, the tensions surrounding the individualization of practice are not clear from a standpoint within everyday practice. Data gathered through observation and interviews left me with the impression that individual and social action (albeit on behalf of more than with people) is fairly evenly balanced within program facilities and time schedules. This impression must be shared since the occupational therapists in this study did not identify tensions around this feature. When I asked therapists about their involvement in social action, they did not report being overwhelmed by requirements for individual action. Instead, Jill talks about trying to "do it all" while handling a caseload of 80 individuals (see Chapter 1.7).

It's crazy - I used to have 80 people on my caseload before the other therapist came - now we still carry about 40 people each and that's too much - I used to be taking work home and doing it at 1 in the morning -there are so few community resources here that you have to keep working away and getting involved in far more than in some other communities. (Observation of Jill, JOB01, 687-697)

Jill refers to her attempts to expand the "few community resources here" by "working away and getting involved". But she describes tensions between attending to social action and her individual caseload as having too much to do rather than having to put the bulk of her energy into managing individuals. Jill's discussion of her "caseload" shows that her strong emphasis on enabling individual action is taken for granted while social action is assumed to be a peripheral part of practice which is squeezed in and around case management.

The strong emphasis on enabling individual action was not fully apparent until I began to examine the textual practices used to account for the quality and efficiency of practice. This documentary evidence shows how the strong emphasis on individual action is organized by individual case management. It seems that the only type of case officially managed in mental health services is a psychiatrically-diagnosed individual (see Chapter 3).

To display tensions around this core feature, i.e., recognizing the interdependence of individual and social action, I first show how occupational therapists emphasize individual action in their concept of independence. I then show how individual responsibility is emphasized in program mission statements. Third, I display the case management processes of enabling individual 'goal setting' and 'case coordination'. Fourth, I present examples of the documents used to coordinate and control the quality and quantity (efficiency) of occupational therapy.

First, Carol displays how the idea of individual responsibility underpins occupational therapy discourse on 'independence'. As Carol talks, we can see how the orientation to enabling individual action is based on individualistic ideas about promoting independence.

Enabling independence, I guess, is the core of what I try to do. I can't give someone independence, nor can anyone else. But you try to give the person the tools so that they can be as independent as they can. Now, how do I do that? I guess through teaching of skills, helping them to problem solve, helping them to identify, first of all what the problem is. Then doing some priority setting and some goal planning. Re-evaluating, coming back - alright, did this work? Maybe it didn't. Let's try something else. How do you feel about this today? Not so good. Ok, let's look at this another way. And, I always come back to - it's your goals - the patient's goals. Ok, then, 'enabling independence'. How would I actually do the enablement? I guess, start at the beginning with the assessment or with the work that I've done with the client. Find out what their goal is. What priority they put on their goal? Ok, let's look at how we can work on the first goal. Second goal, so on. And help them, kind of, to arrive at how they are going to approach that particular goal. For example, if they're looking at job skills, you might do a vocational history. You look at what kind of things they've worked at. What kinds of work would they like to do? Often, an issue is how much can they work? If they haven't been very well, and they're still a little fragile, I might help them to look at working part-time instead of full time to start. (Interview with Carol, CINTOT02, 228-271)

Carol links independence to individual "skills" and the ability to "problem solve". Skills and problem solving ability are presented as the "tools" of independence. The actual practice of "enabling independence" is to engage an individual in "assessment" to find out "what their goal is" and "what priority they put on their goal". Although occupational therapy ideas about person-environment interconnections and involvement in social action appear consistent with the concept of interdependence, occupational therapy's philosophy about independence is highly individualized.

Second, occupational therapists' emphasis on individual action is connected with institutional statements about individual responsibility. As Bev talks about the mission and philosophy of Site B, we can see how the overwhelming attention to individual action is rooted in actual documentation which holds people individually responsible for improving their mental health:

In our mission statement and goals and objectives, we specify that we're trying to help people take responsibility for their illness and care. (Interview with Bev, BINTOT01, 679-672)

Our whole philosophy attempts to attack that belief [that people are controlled by their illness]. From day one, by asking people to set goals for change. To say, this is what I'm going to do to help myself get better....One lady this morning talked about 'getting the crawlies'. She has come quite a way in accepting responsibility for her illness. There was a time when she would not accept the fact that she could do anything about it. And she still says that there are bad days when I can't do anything about it. But now, she will take steps like going out and calling someone up. It's a hard row to hoe. Changing - helping a person change their beliefs. You can't change it for them....A lot of our educational programming looks at that - at ways to change behaviour. And you can't change behaviour without changing the beliefs that lead to that behaviour. (Interview with Bev, BINTOT02, 483-518)

Bev reiterates the institutional position that individual people "take responsibility for their illness and care". The mission is to help people to accept and act on that individual responsibility. The emphasis is on "helping a person change their beliefs" and their "behaviour". The program mission makes no reference to enabling social action - to assisting the community to develop

support services, or to changing funding policies to provide part time employment and social support which might help people who are "getting the crawlies" to "take steps like going out and calling someone up".

Third, Carol shows us how an individualized philosophy about "independence" and individual responsibility underpins the goal setting and case coordination processes of individual case management. Assessing individuals and finding out "what their goal is" and "what priority they put on their goal" are cornerstone processes in case management. Carol indicates that the goal setting process is one of determining a "first goal" then a "second goal". Then she refers to the actual management of goals by indicating that she asks people "how they are going to approach that particular goal". The individualization of these goals becomes clearer when she talks about helping people to think about individual performance described as "skills". Individual skill development is a strategy for enabling individual action such as "working part-time instead of full time to start". Given the difficulties which individuals diagnosed with mental disorders often have with individual skill development and planning, this work is important. Particularly where mental difficulties last for more than a few months, individuals do have problems which require them to develop basic skills for living in society (Woodside, 1991).

Rita's discussion of individual responsibility shows how these ideas shape her actual work of managing individual cases.

I guess it's a matter, as you go through the process really, of letting them make their own decisions. Helping them deal with the consequences. Realizing that they are responsible for whatever happens to them. Now obviously, some people have chemical imbalances and so on. But they can also have at least some control over whether they take their medications, or seek help when they need it. And that kind of thing...just letting them realize that they have a right to feel what they feel and that they have the right to make their own choices. And they are able to. But often times, it takes time guiding them through those choices, and guiding them through the consequences and what do they do next. (Interview with Rita, RINTOT04, 366-450)

We can teach you to set some goals and learn some techniques to manage whatever stresses are in your life....It's not going to be easy. We'll be tough with you. If you say you're going to do certain goals, we'll ask you if you did them and why not if you didn't. But we're also understanding. We're here because we know that people get over their head and need help getting organized and getting to know themselves. But if you're willing to work at it, you can make some changes in your life. These won't be changes we come up with. They will be changes you say you want to make to make your life better in your view. It's whatever you want to do. You won't make all the changes in your life in the program. But we'll help you get started. (Observation of Rita, ROB06, 1043 - 1078)

Whereas Carol gives examples of individual case management, Rita describes how case management actually works. Based on individualistic ideas of independence and responsibility, case management enables individual action in which people take responsibility for managing their own lives. There is a taken-for-granted assumption that individuals' problems arise from individuals' lack of organization and self knowledge. The implication is that individuals have mental difficulties primarily because they are faulty managers of their lives.

The other implication is that the onus is on individuals to solve personal problems. As Rita states, "goals" are the mechanism for exercising responsibility and making choices. Her job is to "teach you to set some goals and learn some techniques to manage whatever stresses are in your life". Rita's job is to "help you get started" but that "you won't make all the changes in your life in the program". She assures Brenda, however, that "we never just drop people on their own". We learn that Rita understands that it is "not going to be easy" for Brenda since staff like Rita will "be tough with you". Rita holds Brenda individually responsible for meeting her goals by asking "if you did them and why not if you didn't". To soften the management tone of vigilance, Rita empathizes with Brenda saying that "we know that people get over their head and need help getting organized and getting to know themselves". Rita makes sure she injects the whole process with a tone of enthusiasm and hope. With overtones of a 'work ethic', Rita promises that "if you're willing to work at it", Brenda can, as an individual, actually "make some

changes" in her life. While the belief in Brenda's active power and personal responsibility as an individual is important (see Chapter 3), these kinds of statements offer no explicit recognition of the interdependence of Brenda's individual action in the local and broad social context of her life.

Case management is not listed as such on program schedules. Therefore, occupational therapists' actual involvement in social action as well as individual action appears to somewhat resemble the ideal described for this feature of practice. Nevertheless, individual case management is pervasive and creates a strong emphasis on enabling individual over social action. Case management begins with assessment and admission (see Chapter 3). However, individual action is organized by various interconnecting processes so that even collective group sessions are actually attending to individual action. Here we can see how assessment of individual problems provides the foundation for individual goal setting and case coordination. Subsequent chapters show how goals guide people's decision making (see Chapter 5), program involvement (see Chapter 6) and orientation to change (see Chapter 7). In the end, progress on individual goals determines discharge and follow up (see Chapter 8).

Each process in individual case management enables individual action even though everyday practice appears to connect individual and social action.

To illustrate⁶, Rita reminds Brenda of her individual responsibility (see above). She then explains the purpose of a goal setting group.

We help you set goals for yourself and then it's up to you to complete those goals. They aren't our goals for you - they are goals you set for yourself. We also help you to set goals which are suitable to your situation since our focus is helping you to cope with your life outside here - your work and the people in your life...so you work with other people in the group. But you all may have different goals. There's a goal setting group where you figure out your goals for each week and report back to the group on the [goals from the] week before. (Observation of Rita, ROB06, 804-841)

⁶ Rita's work with Brenda is highlighted most frequently in this and subsequent chapters since observation in Site R provided the most explicit examples of case management.

Table 2 provides a sample of the individual action which Brenda identified through goal setting over three successive weeks. Brenda's goals were generated by asking her, in turn, to list goals while other group members listened and contributed ideas. Each group member did the same thing as a team member recorded what was said. The list consists of goals for Brenda's individual action. There is no comparable list of goals which would engage Brenda in social action.

Table 2

Goal Setting: Brenda's Weekly Goals (Site R)*

WEEK 1:

1. Make bed daily
2. Do dishes nightly
3. Do some laundry over weekend
4. One compliment to family

WEEK 2:

1. Do laundry on Tuesday
2. Bath animal on Monday
3. Wednesday - visit from Social Worker
4. Go to aquacize Wednesday
5. Thursday, organize 1 closet
6. Friday - organize 2nd closet
7. Do dishes nightly
8. Make bed each a.m.

WEEK 3:

1. Read 1 chapter nightly
2. Make bed each a.m.
3. Make 3 positive statements daily
4. Organize spare room Thursday & Friday
5. Go to doctor's appointment on Wednesday
6. Go swimming Wednesday
7. Organize bedroom and kitchen
8. Cut friend's hair
9. Visit manpower and check paper daily
10. Follow diet

* Reproduced from actual document produced during Goal Setting group.

These individual goals form the framework for program sessions which serve as a mechanism for case coordination. To illustrate, Table 3 lists Brenda's "assertiveness goals" over the same three weeks as the goals listed in Table 2. Brenda's goals for individual action are addressed by developing assertiveness goals described as "give one compliment per day to anyone" or "write three positive statements"⁷.

'Progress' on these diverse actions may be discussed informally so that I often heard Rita asking Brenda in the hall, at the water fountain, or over coffee how she was doing in getting to swimming or following her diet. Or progress may be reviewed in individual or group sessions.

HOMEWORK REVIEW	ASSERTIVE AREA OF CONCENTRATION	HOMEWORK ASSIGNED
WK 1 new to group	compliments to family	give 1 compliment per day to anyone
WK 2 make compliments	positive statements	think & express positive feelings
WK 3 3 positive statements	receiving negative feedback	write 3 positive things per day; think before reacting

* Reproduced from actual document produced during Assertiveness Group.

Furthermore, Rita reported Brenda's progress at staff meetings designated as 'case coordination' or 'case management'. At these meetings, occupational therapists and other professionals report to each other on their management of individual action addressing individual goals. Furthermore, in all but Site M, case coordination meetings are linked with 'Rounds'. Rounds are medically-led team meetings which manage the ongoing medical diagnoses and progress in treating individual patients.

⁷ The structure and program content of the Assertiveness Group are analyzed in Chapter 6.

Fourth, the emphasis on enabling individual action is organized by institutional processes and practices of accountability. Occupational therapy is primarily accountable for the quality and efficiency of enabling individual action not social action. An extended section of Rita's job description (Table 4) shows that her work is actually described as "case coordination" as well as occupational therapy. As well, while occupational therapy's Workload Management System data include reporting of social action under a category of time for "community service activities" (see Section 4.4), these data are primarily used in occupational therapy staffing decisions.

Instead, occupational therapy is made officially accountable for the quality of practice using the documentary processes of 'quality assurance' (Brook & Appel, 1973; Donabedian, 1966). These processes make occupational therapy's practice accountable for the quality of individual case management. As Nora says:

...quality assurance, and all those notions... they're very valid and they're good. But, at the same time, they lead you to develop really structured programs, with very clear [individual] objectives and goals, so that you can then say that your client is meeting the objectives and goals. (Interview with Nora, NINTOT03, 307-315)

Health services management has instituted a large array of documentary mechanisms for controlling quality (Campbell, 1984). Transitional mental health programs operate with only a few of those used in other hospital-funded services. I will briefly display how the emphasis on enabling individual action is organized by two related types of documentation used for 'quality assurance'⁸ in these programs: the health record and the health record audit instrument.

⁸ Although I will use the generic term "quality assurance", the more current discourse and practice refers to "total quality management" or TQM. TQM is managed through an ongoing process defined as a "quality improvement program" or QIP. Accountability for "quality" services is now ongoing rather than a periodic check. This continual expectation of improvement puts practice accountability continually on the line and increases the stress of fulfilling job expectations. None of the sites visited were using TQM or QIP.

Table 4

**Occupational Therapist: Position Description (Site R)*
Case Co-ordinator
Roles and Responsibilities**

The "Case Co-ordinator" is responsible for coordinating all aspects of the care of the patient, under the direction of the Program Director and is also responsible for discipline specific activities for the program. He/She consults with all members of the multidisciplinary team to effectively use each member's expertise in the planning and delivery of care

SPECIFICALLY THE CASE CO-ORDINATOR WILL:

Assessment

1. Ensure availability of relevant data from the patient, family, significant others and previous records
2. Collaborate with the patient, team members and significant others in order to establish priorities of care and to identify problems on an ongoing basis
3. Complete an initial clinical note within seven working days of admission

Patient Care Planning

1. Ensure the development of a treatment plan with realistic goals in consultation with the multidisciplinary team
2. Interpret the treatment plan to the patient and seek the patient's willingness to proceed with it

Implementation of Treatment Plan

1. Co-ordinate the implementation of the treatment plan
2. Review, evaluate and revise the treatment plan on an ongoing basis
3. Document the minimum of one weekly progress note using a goal-oriented format

Discharge Planning

1. Commence discharge planning from the day of admission to ensure the patient is adequately prepared
2. Ensure completion of all necessary discharge documentation by appropriate professionals
3. Complete the Case Co-ordinator's portion of the discharge summary within three working days of discharge

* Reproduced from actual document without location identifiers.

The health record⁹ is the central document used to make occupational therapy accountable for the quality of work oriented to individual action. There is no documentation which holds equal weight to account for the quality of work oriented to enabling social action. In full, the

⁹ The change in name from a medical chart to a health record demonstrates its function as a coordinating device for various health professions in addition to medicine.

record includes documentation of the individual case described as follows: admission/entry, consent, referral (registration), background information ("history"), prior admissions, medical assessment (history, current status), assessment data from other professionals on the team, medical orders, "patient" goals, progress (completed by all ongoing services) related to individual goals, other letters and reports (e.g., lab and consultant reports), discharge (referral to others, medical report) and other documentation related to a case¹⁰.

Rita describes the everyday process of documenting case management in a health record.

You write the problem list. Then you link that to the goal sheet. Then you link that to the progress notes. In the progress notes, I try to mention the problems, like Brenda's finances, and refer to them by the number from the problem sheet. But the progress note is more often a narrative description of what's going on with the person right now - symptoms, mood, that kind of thing - as well as the instrumental behaviours that the goals are linked to. (Interview with Rita, RINTOT06, 427-440)

Individual action is based on a documented "problem list" of individual problems. Individual problems are translated onto a "goal sheet" of individual goals. Work done in relation to individual goals is recorded in "progress notes". It is Rita's documentation of individual problems, goals, and progress which is reviewed for 'quality assurance'. As she says:

If I was doing strictly ot [occupational therapy] and not the case coordination part - it would be much easier for me to describe in detail a meal assessment - lots of detail about how they measured, or whether they could measure. Whereas, with case coordination, when you're dealing with so many other issues that aren't necessarily ot [occupational therapy] related, I just couldn't see myself putting in the time, the energy, or even feeling that it's that important to put all the detail down in a note. For instance, if he had difficulty measuring, I might put down 'had difficulty with measuring, will buy measures' or something. And go on from there rather than describing the whole thing. But I think a lot of that has to do too with the detail and the number of activities - and that's very much constrained by the fact that I case coordinate as well and I have to deal with medication issues, and marital issues and so on which all come up. (Interview with Rita, RINTOT09, 695-720)

¹⁰ Chapter 5 displays health records as integral to hierarchical decision making, and Chapter 7 discusses the legal authority of the health record.

A related document, the health record audit instrument works in tandem with and is complementary to the health record in quality assurance. This document identifies the categories of action which represent 'quality'. Therefore, information in a health record both organizes and is fitted to the categories on the typical audit form (see Table 5). The audit manages the quality

Table 5

Instrument for Auditing Patients' Health Record (Occupational Therapy) (Site R)*

Identification

Referral

Time Reference

Evaluation Methods

Intervention Plan

Discharge Summary

Frequency of Documentation

Signature

Corrections

* Appendix G is the full document from which these headings have been extracted.

of practice by reviewing the documented evidence of individual action. The review examines whether an individual referral has been authorized, services have been dated, and assessments ("evaluation methods") have identified "strengths & deficits" and "goals" for case coordination. The "intervention plan" is evidence of "individual/group" practice based on individual goals.

In addition, occupational therapy is made officially accountable for the quantity of practice through the documentation of 'efficiency' in case management. Efficiency is created as a textual object and calculated as a measure of the numbers of cases managed over time. Data

on numbers of cases per month are entered in a Management Information System (MIS) compatible with provincial and federal data requirements. An MIS sets out informational requirements for management by defining the 'facts' required for the management of an institution such as health services (Campbell, 1984; Cassin, 1990). Typically, as in Site P (see Table 6), the MIS records numbers of people and visits per person. Caseloads are measured by aggregating the number of days of attendance of all cases and the number of cases 'discharged' from the system each month. The MIS makes accountable the numbers of cases coming and going from the system, their "length of stay" (in days) and their frequency (number of "visits").

Table 6

Caseload and Service Time Per Case*
Management Information System (MIS)
(Primary Data Categories) (Site R)

New referrals (from date of admission)
 No shows (from time data)
 Missed visits (from time data)
 Length of stay in working days (discharge date less admission date)
 Average daily attendance (time data/sometimes kept as a separate, aggregate program data form - group attendance)
 # visits of 3 hours or less (time)
 # visits of more than 3 hours (time)
 Closed files (cases with termination dates in that month)

SITE N MIS: (additional categories)
 # patients at end of previous month
 # patients at end of the month

* Reproduced from actual document without location identifiers.

By calculating the number of cases handled per month, the MIS also provides an aggregate calculation of the efficiency of the mental health team as a whole. Therefore, each team member experiences the pressure Jill described (above) in keeping track of a caseload. The implication for occupational therapy is that the MIS sets productivity expectations. Although there are variations between team members, occupational therapists experience implicit pressure

to carry caseloads which are similar to those of other professionals. Therapists let down the team and appear inefficient unless their caseload data correspond to that for other team members. In essence, data requirements for the MIS determine how occupational therapists and other team members spend their day. The documentation of data to account for efficiency ensures that the majority of the day will be spent on enabling individual action. Practice emphasizes individual case management since that is all that literally 'counts'.

The analysis of everyday practice and its documentation displays how individualism is produced and reproduced, not as a theoretical idea, but as the practical everyday work of conducting and documenting the work of individual case management. Case management is a form of objectified management which uses objectified 'facts' for management decision making (See Chapter 2.5). As with all types of modern management, case management coordinates and controls multiple practices oriented to the same function (Braverman, 1975).

Essentially, case management displays the 'method', the practice of individualism in mental health services (Smith, 1990b, p. 45). Furthermore, case management emphasizes individual action through what Smith defines as an "ideological circle" (Smith, 1990b, p. 44). An ideological circle is a textual practice in which 'facts' are extracted from real experience then used to explain and organize that experience. In this particular circle, people's contextual lived experience is ideologically interpreted by creating diagnoses, i.e., 'facts' about individual mental disorders as objects for management (see Chapter 3). From a diagnostic "problem list", individual cases are coached to identify individual 'goals' relevant to the mental 'facts' of their diagnoses. Case coordination enables individual action relevant to these individual goals. The completion of case coordination, i.e., program discharge, is then based on 'progress' relevant to individual goals. Problems, goals and progress in case coordination provide the documentary 'facts' required for the institutional management of the quality of practice. Numbers of

diagnostic cases provide the documentary 'facts' required for the institutional management of the efficiency of practice. Both quality and efficiency are actually textual objects. They appear to be objective measures of practice but they are ideological accounts of work. They are ideological because they describe those facts about practice, such as occupational therapy, which are relevant to the individual diagnostic categories which define the categories of work within mental health services. In using these facts as measures of practice, occupational therapy is made accountable primarily for enabling individual action relevant to categories of individual mental disorder.

The analysis in this chapter does not negate the importance of individuals or the work of enabling individual action. As a philosophy, individualism makes it possible to recognize individuals as active persons with the autonomy and power to act (see Chapter 3). Individualism also recognizes that individuals can take responsibility for their actions (Marantz, 1990; Ryan, 1976; Rueschmeyer, 1986). The problem is that individual case management orients the whole enterprise of mental health services to enable individual action. Individual case management makes the work of enabling social action largely peripheral and irrelevant as a health practice.

4.6 Summary

In historical and contemporary literature, occupational therapy displays some recognition of the interdependence of individual and social action consistent with an ideal empowerment-oriented practice. Furthermore, actual practice in transitional mental health programs displays glimpses of possibility as occupational therapists' work with people in social action, particularly in local situations pertinent to individuals. There are also examples of occupational therapists changing policies, developing community support services or contributing to legislation on behalf of people with disabilities. Some institutional recognition of the interdependence of individual and social action is exhibited in program facilities and schedules. These are structured to support

both individual and collective action within programs. As well, occupational therapy position descriptions and Workload Measurement System include categories which recognize the presence of a small amount of social action, albeit primarily on behalf of rather than with people.

Despite some possibilities for connecting individual and social action, strong tensions surround this feature. Actual practice is drastically narrowed so that the overwhelming emphasis is on enabling individual action. In part, occupational therapy's philosophy of independence narrows practice by emphasizing individual action. As well, mission and other statements narrow practice by emphasizing individual action as a reflection of individual responsibility. However, occupational therapy is narrowed most by individual case management. The only type of case officially managed in mental health services is a medically diagnosed individual. Therefore, individual case management coordinates and controls occupational therapy to produce individually managed medical cases. The emphasis on enabling individual action is particularly visible in the case management processes of 'goal setting' and 'case coordination'. Individuals are prompted to identify individual problems and goals which are managed by enabling individuals to accept responsibility and take individual action to achieve individual independence. Facts about problems, goals and case coordination are documented in individual health records which provide the primary documentary evidence used to determine the quality of practice. As well, facts about the numbers of individual cases are entered in a Management Information System which is the primary method of measuring the efficiency of practice in comparison with other health practices. These textual practices make occupational therapy accountable primarily for the quality and efficiency of enabling individual action, not social action. By narrowing practice to individual case management, occupational therapy submerges its potential for enabling people to connect individual and social action. Submersion occurs by emphasizing individual action and rendering social action officially peripheral and irrelevant.

CHAPTER 5

CONTROLLING COLLABORATION

5.1 Introduction

This chapter adds the egalitarian concept of horizontal collaboration to the two features already identified in an ideal empowerment-oriented practice: recognizing that people have the power to act and recognizing the interdependence of individual and social action. Literature outside occupational therapy indicates that an ideal empowerment-oriented practice involves *collaborating in decision making partnerships*. In occupational therapy literature and practice, possibilities for developing decision making partnerships lie in occupational therapy's commitment to work collaboratively with people and to encourage people to make decisions about their own lives and the everyday activities in programs. However, the potential for developing this feature is constrained in actual practice because people are not generally included as collaborating partners. Specifically, people are not equal partners in decision making about the structure of programs and the institutional structure of health services. In this chapter, tensions around this feature are analyzed using examples of 'decision making' in case management and team meetings. The analysis shows that professionals face difficult-to-resolve tensions between ideals of organizing horizontal, collaborating partnerships and a tradition of professional dominance based on hierarchical decision making.

5.2 Developing Collaborative Decision Making Partnerships: An Ideal Practice

This third core feature in an ideal empowerment-oriented practice involves collaborating with people in decision making partnerships. Development of this feature rests on the first two: recognizing that people have the power to act (Chapter 3); and recognizing the interdependence of individual and social action (Chapter 4): With the addition of this third feature, people are recognized as equal partners in making decisions about their individual lives and the social context of their lives.

Consistent with views on power and empowerment (see Chapter 1.2), decision making is defined as a collaborative process in which people are equal partners in determining individual and social action (Lukes, 1974, 1986). Decision making is not merely a matter of individual cognitive skill (Fisher & Todd, 1986). Decision making is a socially organized process of communicative action (Habermas, 1984). In an ideal practice, decision making is defined to include but is not limited to: clarification of diverse assumptions and beliefs of all persons connected with a decision; analysis of a situation from each partner's perspective (analysis of strengths as well as problems); identification of possible sequences for action from each partner's perspective; negotiation to identify the practical implications of each action and the potential of each action for enhancing the empowerment of people rather than professionals; negotiation to decide the method of selecting action (majority vote, rotating roster, delphi method, etc.); reflection to ensure that power has been shared equally in the decision making process; and, finally, selection of action.

In ideal decision making partnerships, professionals and the people using professional services each voice perspectives and listen to alternate perspectives (Pinderhughes, 1983; Belenky, Clinchy, Goldberger & Tarule, 1986; Zola, 1984). In an ideal practice, professional and non-professional partners accord equal value to each others' work and ideas in negotiating

decisions (Eisler, 1988). Each partner then promotes symmetrical, horizontal decision making processes characterized by mutual interdependence (including mutual dependence and mutual autonomy) (Young, 1990). An ideal practice encourages people to exert whatever control they can in decision making about themselves and their situations (Waitzkin, 1989). People are encouraged to engage in collaborative decision making in everyday practice. Furthermore, an ideal practice structures horizontal decision making partnerships for determining the policies, funding and legislation governing professional and other institutional practices in which everyday life is embedded (Gibson, 1991).

In its broadest form, an ideal practice equalizes decision making power in state practices (Ehrenreich, 1978; Smith, 1990b). This means that an ideal practice presses the state to include ordinary citizens, service providers, professionals, managers and politicians as equal partners in deciding how state resources will be used. In this ideal, professionals themselves dismantle the unequal "banking" concept that professionals are the only experts in society (Freire, 1973). In an ideal empowerment-oriented practice, professionals are equal decision making partners with people who are struggling to overcome oppression. This partnership is possible where professionals publicly acknowledge that people are experts with knowledge grounded in their lived experience of oppression (Freire, 1985). This feature in an ideal vision demands a dramatic transformation of the ways in which professionals make decisions. It demands a new professional code of ethics: that professionals are responsible for ensuring equality in decision making with the people who use professional services (Young, 1990). With this goes promotion of a new public code of ethics: that individuals and communities are responsible for ensuring equality in decision making with professionals. Ultimately, professionals who are developing an ideal practice are actually promoting a paradigm shift. The shift is towards reciprocity, mutuality, symmetrical power, collaboration, partnership and other horizontal forms of relating to achieve

equality in decision making power. The shift is away from the traditional hierarchical organization of decision making in professional work (Freidson, 1986; Illich, Zola, McNight, Caplan & Shaiken, 1977; Coburn, 1988; Larson, 1977; Navarro, 1989).

5.3 Promoting Collaboration: Occupational Therapy Literature

As was seen in the analyses of person-centred practice (Chapter 3) and the interdependence of individual and social action (Chapters 4), occupational therapy literature on collaboration shows tensions in which glimpses of an ideal empowerment-oriented practice are submerged. Glimpses of collaboration shine where occupational therapy stresses the importance of working with rather than doing for people. In these glimpses, occupational therapists enable people to collaborate in face-to-face decision making in everyday home, work, leisure and other situations. As well, there are repeated references to enabling people to develop problem solving and decision making skills. The purpose of such skill development is defined as enabling people to collaborate in therapeutic decisions and in decisions about their own lives. Concerns for collaboration, partnership and equality are increasingly being expressed (Grady, 1992). For instance, the most recent Canadian guidelines (for practice in mental health services) have emphasized collaboration throughout the referral, assessment, planning, intervention, discharge, follow up and evaluation stages of practice (Canadian Association of Occupational Therapists, 1993a). In the 1990's, a renewed interest in collaborative partnerships has emerged as demonstrated in the May 1993 edition of the Canadian Association of Occupational Therapists' National Newsletter devoted to Partnerships. The Newsletter carries descriptions of occupational therapists across Canada who are involved in partnerships, including those with 'consumers' on the committees and Boards of Directors which structure programs.

As well, the ideal is somewhat present in occupational therapy's emphasis on addressing

people's own goals rather than goals defined on their behalf by therapists or others. Respect for people's own goals is, in part, a reflection of person-centred practice (see Chapter 3). But people often identify their goals through a collaborative decision making process with therapists. In both historical and contemporary literature, there are descriptions of occupational therapists encouraging people to be partners in deciding their goals for engaging in 'purposeful' or 'meaningful' occupations (Driver, 1968; Dunton, 1919; Christiansen & Baum, 1991; Kielhofner, 1985a, 1993). Mattingly describes occupational therapists including people in a 'mutual process of reasoning' in deciding meaningful goals (Mattingly, 1991a, 1991b). Following on Mattingly's work, Crepeau describes occupational therapists engaging in 'collaborative reasoning' with people in deciding goals and intervention (Crepeau, 1991).

In general, then, there is evidence of mutuality in occupational therapists' talk about collaboration, partnerships and equality, and in occupational therapy's attention to goals which are purposeful and meaningful in people's own lives. However, tensions exist because the more dominant occupational therapy discourse and practice display ideas of medical and professional dominance (Sumsion, 1993). Most occupational therapy literature refers to collaboration and mutual decision making with people while simultaneously describing how occupational therapists 'treat patients' or 'provide services to' patients. Use of a medical discourse of 'treatment' with 'patients' undermines occupational therapists' collaborative potential as well as the potential for engaging in a person-centred practice (see Chapter 3). Patients are not equal partners in decision making about their diagnosis or treatment. They rely on the expertise of a medical professional who defines the best treatment choices from a medical perspective.

Of concern, occupational therapy's own conceptual framework states that occupational therapists are responsible for defining 'appropriate' frames of reference, assessment approaches, intervention strategies, and follow up plans (Canadian Association of Occupational Therapists,

1991, pp. 69-71). Furthermore, occupational therapy literature contains no critical analyses of ways in which the hierarchical organization of decision making in health services reduces the potential for developing real collaboration. Occupational therapists have yet to describe how to make the paradigm shift from professional dominance to equal partnership in decision making. The idea of collaboration appears to be conceptually limited to decision making about personal goals. As well, the practice of collaboration is inconsistent, often contradicted by professionals assuming to know best about the medical treatment of patients.

5.4 Tentative Collaboration: Glimpses of the Ideal in Occupational Therapy Practice

Actual practice appears to reflect similar tensions as were cited in the literature. In each site, occupational therapists' language and way of working with people offer clues that occupational therapy is not a typically dominant practice. Glimpses in the literature of enabling collaboration are actually present in practice. Five brief glimpses show the occupational therapists in this study attempting to enable some degree of collaboration in face-to-face situations. These glimpses describe how collaboration in decision making is fostered around program participation, goal setting, case coordination, the weekly program structure, and program evaluation.

First, collaborative decision making is fostered around people's participation in programs. Although people are dependent for admission on psychiatric referral and assessment, people are not being held as full time patients and wheeled into rooms by porters acting on doctors' orders. They decide whether or not to attend the program each day. Unlike job training with financial incentives, there is no financial incentive for attending. In the various activities scheduled throughout the day, people decide whether or not to participate. The week's activities are not a mystery. People know what is happening since they generally receive a copy of the weekly

schedule on admission and can always refer to a copy which is posted on a large schedule board in the lounge or main hall. It is people's own decision how much, how, when, and with whom they participate in assertiveness, stress management, time management, goal setting, weekly or weekend planning, food services, maintenance, clerical work, industrial subcontracting and other sessions (see Chapter 6 re program sessions). There is no doubt that professional referrals (particularly from 'The Doctor') may be taken as an order rather than as a choice. But, as Pat tells 'Mike', a person considering attending:

Would it help if I gave you a bit of information on the program and how it works? Then maybe you can decide from there whether you want to take part.
(Observation of Pat, POB25P1, 322-326)

The decision is ultimately Mike's. This phrase "you can decide...." is repeated over and over by occupational therapists in virtually every type of session. Therapists remind people almost daily that they have choice and control with regard to their decision to participate in programs.

Second, there is some collaborative decision making in goal setting. It sounds contradictory to say that 'cases' which are being managed share some degree of control in decision making. However, in Chapter 4, we saw Rita prompting Brenda to make her own decisions about goals and to incorporate these into assertiveness goals. Here, we can see Bev talking about people making decisions to set goals to change their lives since "you can't change it for them":

...from day one, by asking people to set goals for change...changing - helping a person change their beliefs...you can't change it for them... (Interview with Bev, BINTOT02, 483-518)

And as Rita says:

I guess it's a matter of letting them make their own decisions. Helping them deal with the consequences. Realizing that they are responsible for whatever happens to them...(Interview with Rita, RINTOT04, 366-370)

Rita's statement exhibits the tension: she talks of "letting" people make decisions. This language

suggests that it is actually the professional who controls people's opportunities to make decisions. But even the intention of relinquishing control is not a characteristic of the traditional dominance exercised by health professions (Hearn, 1982; Illich, 1977; Johnson, 1972). Certainly, encouraging people to set their own goals and helping them to deal with consequences is not sufficient for truly collaborative decision making. But it is a necessary ingredient in enabling people to be equal partners in decision making. Besides, this kind of talk about people making decisions provides a glimpse of an ideal practice with collaborative decision making partnerships.

A third glimpse is available in occupational therapists' advocacy for people to be partners in the decision making associated with the coordination of their cases. Jill stresses people's ability to know what is best. She describes occupational therapists as "spokesmen" for people in team meetings which otherwise exclude them from decision making.

We often act as spokesmen for the individual. I know I have in the past. If so and so would like to live independently - or in supportive housing. Sometimes the majority of people on the team are not looking at the desires of the client. And we're often the spokesmen there saying, but this is what they want to do. Or work is a good example. We had a real row here a while ago. Some social centre in the community was hiring on some people. They had a grant and were hiring on people. So a lot of people wanted their clients to go and work there. And some of the clients weren't interested. So it was other people deciding what's best for the client. So often times, we're the ones who have to sit with the team and say 'but this person doesn't want...' So we try to facilitate that - that it's the individual's life and they want to make these decisions - and don't you think we have to respect that? Sometimes it works - not all the time. (Interview with Jill, JINTOT01, 1624-1654)

Jill is not going so far as to suggest that decision making needs to be an equal collaboration. Nor has she found a way for people to advocate for themselves in meetings. But she recognizes that people ought to participate in decision making about themselves.

Rita, too, describes how people are guided as collaborators in making decisions about actions which relate even indirectly to goals. Brenda's goals (see Tables 2 and 3, Chapter 4.5) all appear to require management of daily living skills. However, these goals require Brenda to

make decisions about when, how and with whom she will act. Part of case coordination involves prompting people to make decisions. Instead of managing people by doing the case coordination for them, Rita describes how she encourages people to make their own decisions about actions as simple as making "phone calls".

Rita: Here, it's trying not to *do* [Rita's emphasis] even phone calls for patients. When I worked in in-patients, we would often do the phoning for information on, say, a leisure club. Then, I'd give the patient the information. But here, we might do some preliminary calling to get an appropriate number of a person for the patient to talk to when they call. So, you're really trying to facilitate them doing every step...so I might make a call to get some information - is this the number to call about such and such. Ok, thank you. Then hand the number to the patient.

et: When would you consider that it would be useful to have them go through the steps of finding out that it was the wrong number...?

Rita: We might observe their level of problem solving and their level of communication. For instance, Brenda might be an example of someone who's very concrete. But I think she can figure out who to call at what particular time - or where to look for a number - so I might let her do that - whereas John, for example, not only because of the language difficulty, but because of the whole communication style - I don't think the person on the other end would know what he was talking about - let alone if he had called the right place. I don't think he'd understand that or know what to do next. So, we're looking at problem solving, decision making and communication style (Interview with Rita, RINTOT10, 89-156)

Rita contrasts her case coordination in transitional mental health programs with her previous work in "in-patients". However, she continues to judge Brenda's ability to "figure out who to call at what particular time - or where to look for a number". With John, Rita assumes that it is best not to leave him to find a telephone number because "I don't think the person on the other end would know what he was talking about - let alone if he had called the right place". With awareness that decision making may be limited by mental disturbance, occupational therapists like Rita exercise professional expertise to determine how much decision making is possible.

A fourth glimpse of collaborative decision making can be seen in some instances of program planning which involve planning the weekly program structure. The group planning meetings, which exist in all programs except Site M¹, encourage collaborative decision making around some aspects of the program structure. These group sessions, in part, serve as a warm-up to greet people, check what is happening, and tend to the interpersonal dynamics of the group. In part, they are also a small collective forum for planning social action (see Chapter 4). But people are also encouraged to comment on the order of events and even the types of events on the program schedule. People suggest alternative locations for the weekly outing which is usually outside the program facility in shopping, recreation, or visits to heritage or tourist sites. Professionals and some group members ensure that everyone who wishes to has a chance to talk. Where the group decides to re-organized the schedule, professionals or people reprint weekly sheets and change the posted schedule. The organization of outings is negotiated to determine who will be involved, where, who pays and other arrangements. In some of this negotiation, the egalitarian processes defined as ideal empowerment-oriented decision making (see Section 5.2) are present: situations are analyzed from various perspectives; possible sequences of action and their implications are negotiated; and decision making methods such as voting or taking turns in choosing are employed. People are asked to identify ideas, perspectives, and implications for various program options. As in the previous examples, occupational therapists and other professionals retain considerable control. Nevertheless, the atmosphere is one of mutuality, respect for diverse perspectives and expertise, and involvement of everyone in decisions about day-to-day activities. In these examples of program structuring, then, there is a clear glimpse of collaborative decision making consistent with an ideal empowerment-oriented practice.

¹ Site M has individual and group sessions but this is not a group program where participants might structure the overall program.

The fifth glimpse incorporates some collaboration in program evaluation. People are asked to comment on the structure and their experience of specific programs through 'consumer' evaluation. Therefore, program evaluation is not restricted to a professional perspective. As people leave the program, they are asked to comment on the 'helpfulness' of the program or their 'satisfaction'. At the time of the study, four of the seven programs used questionnaires for this purpose. Three programs use a written 'satisfaction survey' similar to that in Site R (see Table 7). People collaborate in decision making by rating whether or not specific sessions or events were helpful.

Table 7	
General Satisfaction Rating (Site R)*	
1.	How satisfied were you with the program? (7 point scale: very dissatisfied... very satisfied)
2.	How helpful was each part of the program to you? (5 point scale: not helpful...very helpful & not applicable)
	<ul style="list-style-type: none"> - goal setting group - assertiveness group - stress management group - health & lifestyle group - community meeting - exercise - medications - family/friends involvement - talking to other patients - talking to staff individually
3.	Comments
* Reproduced from actual document without location identifiers.	

In Site N, a detailed questionnaire diverges from those typically used. It includes questions about people's perception of equality (see Table 8). The survey used in Site N displays an attempt to evaluate people's perception of their control decision making by using words such

as "choose/choice" and "have a say". There is reference to equality in the questions about whether "the staff treat me as an equal".

Table 8

Client Satisfaction Survey (Site N)*

Answer: always, sometimes, never

1. Case coordinator gave correct program information and descriptions
2. The program components I am involved in are beneficial
3. I can choose to change components when I feel I'm ready
4. I feel that I am receiving the services offered to me at the time of admission
5. My case coordinator treats me as an equal and shows concern and understanding towards me
6. My case coordinator is there for me to discuss problems and concerns when I need to discuss them
7. The staff teach me skills in order to reach my goals
8. The staff teach me how to use resources in the community
9. I have input into what my program will be
10. My case coordinator and I discuss my progress in meeting my goals
11. I use the skills I learn in my everyday life
12. I am involved in planning my goals
13. I learn new skills in the groups I attend
14. Transportation to the program is a problem for me because of money, distance, fear
15. Staff at the program help me feel comfortable in the program
16. My case coordinator chooses my program goals
17. The staff treat me as an equal and show concern and understanding towards me
18. Clients have a say in how the program is run
19. I have the opportunity to make my own choices/decisions
20. I would recommend the program to someone in a situation similar to mine
21. I know my program goals/rehabilitation
22. I find it hard to follow the policies of the program (attendance, schedule, personal hygiene)
23. Staff are willing to talk with me about relationships
24. I like the location of the program
25. The program is a pleasantly furnished and well maintained environment
26. I can make a choice about a community placement when I am ready
27. How helpful are the following types of treatment in your rehabilitation program? (fitness, individual counselling, personal effectiveness training, leisure/recreation, work units, peer support)

* Reproduced from actual document without location identifiers.

Here, I note that the occupational therapist and other staff in Site N have paid unusual attention to enabling collaborative decision making in program planning and evaluation. We can see psychosocial rehabilitation's philosophy of active members at work (see Chapters 3.4 and 6.5). The daily check-in meeting is chaired by members, and members are encouraged to express opinions and make choices on work projects, recreation and other aspects of the daily routine of the program. People in Site N are included in the development of policy documents and are co-writers in requests for special grants' funding. Professionals usually speak publicly with members of the program. People's construction as active members appears to make at least some collaborative decision making with professionals a possibility. The philosophy of psychosocial rehabilitation seems to engender consciousness and action in which professionals and members actually challenge some provincial and federal practices which limit collaborative decision making in structuring specific program initiatives.

5.5 Controlling Program Structure: Contradicting Collaboration

The five glimpses of collaborative decision making show occupational therapy's interest and actual practice in promoting collaborative decision making. Decision making around program participation, goal setting, case coordination, program planning and evaluation exhibits some (albeit varying) degree of partnership between professionals and the people who attend programs. The problem is that, even in these everyday aspects of practice, the potential for collaborative decision making faces tensions. Occupational therapists do relinquish some control in favour of people making choices and decisions. Nevertheless, they retain the prerogative to judge what is best for people. They also retain control, with team members and managers, of the basic space and time structure of programs, the structure of case management, access to team decisions about people, group meetings to plan the schedule of events, and the questions asked

in seeking consumer views of the 'usefulness' of and their 'satisfaction' with the program.

To analyze these constraints, I discuss, first, how people's mental difficulties and their reliance on professional expertise intersect with institutional processes to reproduce hierarchical processes of decision making. Second, I illustrate how hierarchical decision making organizes occupational therapy so that each glimpse of collaborative decision making simultaneously invites yet controls collaboration.

One explanation for occupational therapists inviting yet controlling collaboration and control is that some people really are incapable of making many decisions. Collaborative decision making is difficult to incorporate in mental health practice since the very nature of mental disturbance is that decision making is impaired or at least clouded by preoccupied thoughts, major emotional concerns and so on (see Chapter 3.4). The ability for decision making is reduced where hallucinations, delusions, severe depression, mania, neurotic anxiety or some other severe problem clouds their interpretation of reality. People with impaired decision making may need professionals to make decisions which ensure their protection. For instance, people sometimes need professional expertise to control them from harming themselves or others.

However, most people retain some decision making capacity. They have their own view of what is best for themselves. Although professionals may be wary that people do not always know what is 'best', most people have a strong desire to make choices and exercise some control in their life (DeJong, 1979; Maslow, 1943; Zimmerman & Rappaport, 1988). In all situations, people have some grounding for making decisions since they have subjective knowledge of their mental difficulties and their life circumstances (Rose & Black, 1985). They also have subjective knowledge of the experience of working with professionals in mental health services. Their subjective knowledge of the institutional structure of mental health services is grounded in their actual experience of specific program structures. Therefore, mental disorders, in themselves, are

not sufficient justification for controlling decision making beyond personal choice.

Another explanation for occupational therapists inviting yet controlling collaboration is that people may be invited to collaborate but they are reluctant to collaborate in making decisions.

Even with the best of intentions, as Pat says:

We have to struggle with trying to get people to make as many decisions for themselves as we can without us having to take the leadership so that something actually does happen here. (Interview with Pat, PINTOT01, 802-809)

Some people seem to rely on professional expertise, particularly if the professional is a 'Doctor'. Pat highlights awareness that people assume that professionals control decision making.

We [professional team members] are increasingly realizing that the doctor just says [to people]: 'you're going'. At first, we used to assume that people were just being manipulative in saying that they knew nothing. But I think it really is true that the doctor gives no real explanation. And they just arrive. So I felt that [a new person attending the program] had not been part of the decisions. And I wanted to give her time to think. (Observation of Pat, POB25P1, 453-463)

People decide whether or not to attend a program by deciding whether or not to comply with doctors' orders even if the "doctor gives no real explanation". Pat elaborates on the process of people's decision making about "whether or not to come" to a "voluntary program".

I suppose if you want to look at it in black and white, this is a voluntary program. So they've made the choice whether or not to come. If they've come, then we expect them to participate. And if they're not participating in the types of things we have, we find out why not. And if it's not something we want to change, we do suggest that they leave the program. People, theoretically, once they choose to come to the program, choose to be in all parts of the program. It's not, I'm going to take Parts A & B and leave the rest alone...You're not deciding what group therapy is. You are, in that you're 1 of 8 or 9 people who has some impact on what the discussion is or what happens or whatever. But you don't decide that - instead of group therapy, we're going to have an outing, or learning group, or whatever. (Interview with Pat, PINTOT08, 1104-1153)

The program requires people to participate in decision making about access and admission to the program. However, Pat points out that to choose to come to the program is to comply with the rules for participation. Staff "expect" people to participate and if they do not participate "we find out why". Staff will determine how to "change" the program to suit those who decide

to enter. But she is clear that the options for change are minimal so that people either take or leave the program as it is. Once in the program, people decide what "impact" they will have on the group discussion. But they are "not deciding what group therapy is" or whether "we're going to have an outing, or learning group, or whatever". In reality, people have so little control over program structure that they do not see themselves as leaders or amateurs who might generate interest and enthusiasm about participation. In Site P, I asked one group how people knew who would initiate discussion and what to talk about. 'Wilma' replied:

This is the first time I've heard this - that we're supposed to get the ball rolling. I thought the staff were supposed to do that. (Wilma in Site P, POB13P1, 478-482)

Collaborative decision making exists. But people's decisions are limited to choices about complying in programs where "staff" are "supposed to get the ball rolling". In essence, Wilma's response displays an hierarchical order of decision making which excludes people from decision making about the program structure itself. Wilma seems to have assumed that people never initiate discussion. She displays the lived reality of people's choice in these programs. The choice is that of compliance or non-compliance with staff initiatives.

Although the first two explanations display important elements in the contradiction between inviting and controlling collaborative decision making, a more fundamental explanation becomes apparent through analysis of institutional processes. Tensions arise because occupational therapists actively attempt to be collaborative in an institution oriented more to controlling than enabling empowerment. Occupational therapists engage in contradictory processes as they encourage decision making while simultaneously excluding people from making decisions about fundamental structure of the program. As Pat indicates (above), occupational therapists are aware of limits. Yet, institutional processes organize occupational therapy to reproduce a decision making hierarchy in which people's subjective expertise is dominated by professional expertise

(Freidson, 1986; Illich, Zol, McNight, Caplan, & Shaiken, 1977; Navarro, 1986). The hierarchy is reproduced in "differentiations of policy-and decision-making capacities" (Smith, 1990b, p. 93).

On observing that people are allocated choice within pre-determined program frameworks, I decided to ask people what they would change about the program if they were asked. I met with eight people one afternoon in Site P. Without professional team members in the room, I asked what these people would change to make the program more ideal. As people talked, I prompted one person to write ideas on a flip chart using people's own words as much as possible. If an idea seemed like a duplicate, I asked the person expressing it to look at the list and decide if a point was already there. The point was added if there was any uncertainty that it had been covered. In about an hour, those present came up with five ideas which they wanted written on the chart (reproduced in Table 9).

Table 9

People's Suggestions for Program Change (Site P)*

1. groups in the morning and activity in the afternoon with one-to-one time available in the afternoon
2. more explanation [from staff and people attending] so we know why we are doing things
3. staff and patients more a unit not two separate groups, e.g., lunch
4. more groups which actually teach you something
5. more organization of physical space

* Reproduced verbatim from flip chart (POB27P1, 412-420).

Although there was lots of discussion, these were the only points which, when I asked 'is that a point to write down', someone said 'yes' and put it on the flip chart. Then, a vocal group

member called in the staff, including the occupational therapist, to listen to the ideas.

After listening, the staff members stated that they appreciated the ideas, found them useful, and would consider them at a professional staff meeting. At the meeting a few days later, the agenda included consideration of people's suggestions about the program. While staff members made reference to people's ideas, it was Pat who spoke up saying:

I understand that the group was saying that they don't feel that very much is happening here and I think we need to listen to that. (POB28P, 285-289)

Despite Pat's attempt to legitimize people's ideas, she and the other professionals controlled decisions about the implementation of these ideas. In the end, the weekly schedule was adjusted and a new 'lifeskills' group started by the psychologist who wanted to introduce an action role play session as a response to people's request for "more groups which actually teach you something" (#4). Group times were shifted to the morning (#1), and time for "activity in the afternoon with 1-1 time available in the afternoon" (#1) was scheduled. The professionals committed themselves to facilitate "more explanation [from staff and people attending] so we know why we are doing things" (#2); one day a week was scheduled for professionals and people to eat lunch together (#3); and, group members were invited to participate in the "organization of physical space" (#5).

As I reflected on my invitation to people in Site P to list ideas for change, I began to see a range of decisions which they had omitted. If directed to talk about a broader range of decision making, would these people have decided that psychiatric diagnosis and individual case management were appropriate mechanisms for enabling them to resolve their mental difficulties? Would they have decided that the quality and efficiency of professional practice be based on their lives being managed as individual medical cases? Would they have decided that seeing an occupational therapist in scheduled sessions every day for weeks is more efficient than possibly having an occupational therapist work with a few of them intensely for a few full days at a time

at home or in a place of employment?

I found the exercise enlightening since it shows that the people who attend mental health programs are participants with occupational therapists and others in reproducing the decision making hierarchy of provincial mental health services. People's suggestions for changing program structure fall within the decision making boundaries allocated to them. They are welcome to suggest shifts in scheduling and to request the opportunity to evaluate 'satisfaction' with reference to the separate eating habits of professional staff and the organization of physical space. Professionals respond by deciding how to institute these suggestions to adapt or actually change the program structure.

Even when a vision of an ideal program is solicited, the dividing line remains intact. I feel confident that these people would have ideas for making decisions about program structure if asked specifically. But without prompting, their ideas did not trespass over an invisible boundary line which excludes them from decisions about overall programs and mental health services as a whole. People seem so used to assuming that the structure is already present that they do not question its presence or form.

With heightened awareness of a hierarchy which excludes people from top level decision making about programs, I was able to see more clearly the constraints surrounding each glimpse of collaborative decision making identified in Section 5.4. The glimpses are real and display collaboration in talk and action. However, collaboration is controlled.

The first glimpse cited was that people make decisions about attending and participating in specific sessions within programs. And as Pat observes, people may decide their "impact on what the discussion is or what happens". But they do not decide what the sessions will be. The presence of a predetermined program structure controls decision making about the locations, time frames, philosophy and funding which determine program sessions (see Chapter 6 for more on

program structure). When people in Site P were asked to comment on the program they were attending, their comments were about the organization of equipment and the division between individual and group time. The basic structure of a five day, Monday to Friday, day time program led by professionals in particular locations was not even raised for discussion.

The second glimpse cited was of people collaborating in decision making in setting the goals required for individual case management. But the range of acceptable goals is implicitly controlled by the group design. Through observing peers, new cases implicitly learn that if they decide to name non-behavioural individual goals, or they identify goals for collective social action (see Tables 2 and 3, Chapter 4), they are out of line. As well, the sites, methods and other features of groups are established by professionals who consider people's ideas as they did the suggestions generated during my session with people in Site P. People are caught in a contradiction: they are expected to initiate group discussion, but they are expected to initiate discussion relevant to people's individually diagnosed problems. Professionals know what is relevant; people, like Wilma are left to learn that by observation. Pat's reflection on Wilma's comment was, as she said, a 'moment of ah ha' in which she herself raised the question:

Are the professionals actually interfering in what's supposed to happen in this group?
(Observation of Pat, POB13P1, 612-616)

The third glimpse was case coordination. At team meetings, Jill is an advocate for people making decisions about the management of their cases. However, people are not conceptualized as equal partners since they are conceptualized as cases, i.e., objects rather than active people. People are not members of the case coordination team except by invitation from professionals. Professionals manage cases by deciding how much control people are capable of exercising in even basic activities such as making phone calls. As well, only professionals coordinate the management of all cases on a caseload. People may be individually included in case coordination meetings or medical rounds (see Chapter 4.5). But individuals simply attend to make comments

on and hear decisions made about their own cases. Their decision making extends to their personal case but not the management or structure of programs overall.

The fourth glimpse cited was of people collaborating in decision making in planning meetings. Yet, planning, too, is carefully controlled. As described above, people are encouraged to be decision making partners in deciding the day-to-day activities and topics of interest for discussion. However, they are only beginning to be included as decision making partners as consumer representatives on the committees, boards of directors and other planning groups which control mental health services overall. Site N, with its psychosocial rehabilitation philosophy of members of a clubhouse (see Chapter 3.4, Footnote 8, Chapter 5.4 above, and Chapter 6.5), stretches the line more than the other programs. Site N actually challenges the existing program structure by changing hours of operation, applying for special funding grants and other actions which are normally contradictory to policies for government-funded programs (see examples of social action in Chapter 4.4). But, even in Site N, the partnership in group planning is limited to decisions about that specific program.

Since people are not members of the team, it is clear that the fifth glimpse, consumer satisfaction ratings, is a controlled form of collaborative decision making. These are unofficial evaluative opinions which are gathered outside the official processes used to account for the quality and efficiency of practice (see Chapter 4.5). People's opinions have value in making specific programs accountable to those who attend. However, official decision making about the quality and efficiency of programs is an objectified documentary process. People are not partners either in producing the documentation or the decisions about these two types of accountability.

The barriers to enabling collaborative decision making are considerable. At present, people do not even have observer or correspondent status on the team. Quite the contrary. Occupational therapy position descriptions, such as Rita's in Site R (Table 1, Chapter 4) require

therapists to "evaluate", "determine", "implement", "progress", "assess", "refer", "record", and "promote and practise good interpersonal and interdepartmental relationships". In descriptions for occupational therapy case coordinators, such as Rita's extended position description (Table 4, Chapter 4), assessment requires occupational therapists to "collaborate with the patient, team members and significant others in order to establish priorities of care and to identify problems on an ongoing basis". This statement confirms that collaboration is encouraged in determining priorities for individual action in case management. However, beyond the personal realm, occupational therapists are required to coordinate and control individual case management.

Besides, like other professionals, occupational therapists have privileges not available to people attending programs. Therapists may choose whether or not to eat with people as highlighted in people's Suggestions for Program Change (Table 9 above). Occupational therapists also have the privilege of taking coffee and lunch breaks with professionals and managers who are generally out of bounds as meal partners for patients. Other observable privileges are that professionals have offices while people do not; professionals (but not people) have bookshelves of texts and journals and are given paid time (and some refunds for expenses) to attend education sessions such as rounds, courses, and workshops; professionals have access to institutional meetings and documentation which are out of bounds to people; and so on.

Overall, occupational therapists' commitment to and actual examples of collaborative decision making are each constrained by institutional decision making processes and the privileges which seem to accompany hierarchical processes of control. These processes are reflected in (and organize) actual practice. Glimpses display a contradictory practice of controlled collaboration. As Rita says below, the team has responsibility to "assign" and "give histories". The team is not currently open to full and equal partnership. Professionals "assign" cases to each other and "give" their histories to other team members who do not know them.

It's supposed to be really a case management meeting. In the sense that we will assign new cases and give histories if there have been new cases assessed or what have you. (Observation of Rita, ROB08, 329-331)

Furthermore, Bev's comments clearly indicate that decision making about case coordination is controlled by the "staff".

This time is for the staff to meet to check in with each other - to touch base, to bring up questions, to make last minute plans for the day, to organize to respond to what the day looks like, how many people appear to be showing up, who will and will not attend and what implications and demands that will have for the program. (Observation of Bev, B0B01, 163-173)

Certainly people collaborate with occupational therapists in managing their own cases. However, when the team meets to coordinate work between cases, people need an invitation to join in. The invitation is for people to offer suggestions and advocate for their own ideas before professionals create the documentary (official) record noting decisions about people's admission, ongoing participation or discharge from programs. My observation is that occupational therapists and other professionals attempt to include people in everyday team decisions. But when I asked why people are not official team members, two dilemmas were usually raised.

One is that people's presence decreases the decision making efficiency required for case management. Unlike professionals, people would need to learn the institutional organization of assessment, admission, case management, team and other policies and procedures before they could make decisions. Moreover, they would need to learn the documentary processes used for decision making in health services (Eakin, 1984; Florin & Wandersman, 1990; O'Neil, 1992).

Concerns for decreased efficiency if people become team members point to an institutional ethic which values immediacy and speed rather than equality in decision making. The aim is to complete production as quick as possible rather than to foster the development of a product which, in the end, may cost less but has more immediate costs. Professional decision making is the quickest method to complete the production of cases since professionals know the

institutional method of case management. It takes longer to enable partnership. Enabling people to become decision making partners means educating them to develop and interpret institutional policies and decision making practices. This type of education has more immediate costs although it might eventually decrease people's dependence on professional services.

The other dilemma raised in including people on the team is confidentiality. Professionals cite their codes of ethics and job requirements as guidelines for respecting the confidentiality of people being discussed (Rinas & Clyne-Jackson, 1989; Rozovsky & Rozovsky, 1990). People are seen as having no comparable guidelines, particularly since, unlike professionals, they are not legally liable for breach of confidentiality. This means that there are no documentary processes which would protect professional liability if people are partners in decisions which turn out to cause harm to themselves or others. These explanations show difficulties for collaboration even within the interpersonal, everyday working of teams. They point to the near impossibility of considering these people as collaborators in deciding about the whole of mental health services as long as they are not even full partners in managing their own lives.

Explanations about confidentiality restrictions for people being decision making partners point to legal barriers which are not easily bridged. In particular, legal requirements for controlling access to health records prevent the use of this document as a vehicle for collaborative communication. An example of a Policy on Confidentiality in Site P (Table 10) indicates that the "primary purpose" of the health record is as "a medium for communication". However, it seems that the health record's more powerful "primary purpose" is to protect professional and hospital liability should people bring professional charges or financial claims against the institution (see Chapter 7.5). Therefore, legal restrictions around confidentiality serve to control collaborative decision making since discussion of information is limited to "those delivering health care".

Table 10

Policy on Confidentiality (Site P)*

... The primary purpose of the Health Record is to document the course of an individual's health care and to provide a medium of communication amongst those delivering health care. Unless both patient and practitioner can be assured that the Health Record will remain confidential, they may withhold information, thereby diminishing the value of the record and the quality of treatment.

Aside from the sharing of essential information by those people caring for the patient, there are three other ways in which information may be released:

- 1) Upon court order
- 2) Upon the written authorization of the patient
- 3) Upon request of a Minister of Health or agent

... Any misuse of health information shall be considered a breach of confidentiality and shall be reported to the Executive Director. Disciplinary action will be taken up to and including termination of employment.... [followed by a section requiring staff to sign a Pledge of Confidentiality]

* Extracted from Policy on Confidentiality, Personnel/Administrative Policy and Procedure Manual, 1986.

Occupational therapists are legally prohibited from showing written information to anyone "aside from ... those people caring for the patient" on penalty of "disciplinary action...up to and including termination of employment". Without signed consent, occupational therapists cannot even reveal if someone attends a program. Although confidentiality policies do not deliberately control collaboration, the threat of loss of employment serves that purpose. Occupational therapists can promote people's understanding of the information in the record by summarizing the essence of documents. However, the Right to Refuse Release of Information to patients (in Nova Scotia, but typical of other provinces) clarifies that:

...the hospital or physician may refuse to make available patient medical records if there are reasonable grounds to believe it would not be in the best interest of the patient.

(extracted from the Right to Refuse Release of Information section of the Nova Scotia Hospitals Act, 1988)

It is the physician and professional workers who sign approval for release of information. They, not "the patient", are officially designated to determine the "best interest of the patient". Moreover, people and professionals generally wish to uphold confidentiality about people's personal situations. On the one hand, people continue to experience negative consequences if landlords, employers or others discover their psychiatric history. On the other hand, professionals face ethical and legal restrictions in disclosing people's psychiatric history.

Furthermore, the results of decision making about case management are reflected in the hospital and provincial policies, procedures and budgets which are inaccessible to cases. Yet, these are the documents used to make decisions about specific programs. As an example, an excerpt from the Service Manual" in Site R describes a program which was structured without any direct involvement from the people who have attended this program (see Table 11).

Table 11

Service Manual: Excerpt from "Program Description" (Site R)*

[Site R] provides a short term transitional program between inpatient (sic) case and community living. In some cases it may provide a preventative service as an alternate to inpatient care for those requiring some support and intervention in community living skills. Home visits are an integral part of the programme and the major focus is on health and community outreach.

Programme planning is individualized providing:

1. behavioural/functional assessments
2. skill development
3. involvement of significant persons in the patient's life
4. community integration
5. comprehensive discharge planning

* Reproduced from actual document without location identifiers.

Decisions that this will be a transitional program, that it will address medically diagnosed patients, and that it will operate primarily through a system of individual case management have

all been made beyond the everyday activities of programs. These decisions have been made hierarchically, not collaboratively, by those who govern mental health services.

For instance, the locations and hours of operation of this and similar mental health programs have been determined by the provincial government and hospital managers. Decisions about the hours are controlled by union agreements and professional contracts about hours and salary. Hospital managers, government workers, union negotiators, and selected professionals have collaborated to one degree or another in making these decisions. Decision making about program philosophies is made by professionals and managers who decide the philosophic emphasis in each program. However, the ideas, beliefs, values, methods and approaches associated with a particular philosophy are all decided by professionals external to those working in these programs. Decisions to support particular philosophic ideas and assumptions may or not be documented in the official minutes of government departments. Rather, philosophies tend to be documented most clearly in professional texts and journals. The development of these philosophies is generally an academic and professional process which rarely includes those who use professional services².

Therefore, the control of collaborative decision making is not merely an oversight which can be rectified by extending an invitation for people to join team meetings. Nor is control an intentional act of professional arrogance. In part, collaboration is limited by people's mental difficulties and their reliance on professional decision making. As well, collaboration is controlled in everyday practice by professionals, as in the five glimpses. Professionals control program structure and group goal setting while also sustaining their professional privileges.

² This is not to say that people have no access to professional texts. Virtually all programs have their own library or at least have access to a hospital library. However, these libraries tend to emphasize medical texts (especially in hospital-based programs) with only a few occupational therapy and other texts. Outside programs, professional texts are available in professional or university libraries in which ordinary people rarely have borrowing privileges.

However, control is more fundamentally organized in institutional practices which account for the quality and efficiency of individual case management (see Chapter 4). Efficiency is determined by the number of completed cases produced per month and year rather than the number of people who become decision making partners in all institutional processes. Furthermore, institutional practices limit collaboration by controlling the legal conditions for maintaining confidentiality. All institutional meetings and documentation regarding policy, health records and program information are based on professionals who assume to know what is best for people. This institutional decision making arena is officially out of bounds to the people who attend programs. The analysis has show how control over collaborative decision making is organized through the actual activities of mental health services. Two processes stand out in controlling collaboration: team decision making processes which require prior knowledge of the policies and procedures of mental health and confidentiality policies and legislation.

Certainly some provinces are making changes, particularly in mental health services. Mental Health Advisory Boards within government are including people as 'consumers' who then have access to decision making discussions about policy development. This is an important development towards collaborative decision making. However, of the twenty-four (24) members listed for one Advisory Board for one of the study sites, none are consumers. As is typical of these boards, there are representatives from local mental health agencies, teachers' unions, the barristers' society, nursing associations and other local hospitals. The only possibility for collaboration by people is by taking one of the three positions for members-at-large³. Even if consumers are elected as members-at-large, they are generally there as individuals without the power of social and economic status behind them (Eakin, 1984; O'Neill, 1992).

³ The actual list is not provided since the community would be easily identifiable within Atlantic Canada.

One final comment on collaboration is that, in the hierarchical allocation of decision making power, occupational therapy is not itself an equal partner in making decisions about the institutional organization of programs. Occupational therapy collaborates in developing ideas about the day-to-day program structure and the functioning of the team. Occupational therapists are partners in making decisions about program schedules, types of group sessions and people's access to services. Some occupational therapists are even involved in social action to change institutional processes. For instance, Carol is on a task force to re-organize provincial mental health services (see Chapter 4.4). However, decisions about institutional processes, such as categorizing people and accounting primarily for individual case management have so far been out of bounds to occupational therapy. While occupational therapists' and other team members' opinions are sought (just as people's opinions are sought in specific situations), the final decisions about categorization, accountability, risk management, budgets and legislation are hierarchically controlled by those who manage transitional mental health programs within provincial and federal mental health services.

In the end, possibilities for collaborative decision making are constrained by hierarchical processes of control. The people who attend mental health programs are at the bottom of the hierarchy and are allocated decisions about themselves and their immediate surroundings. Professionals, such as occupational therapists, occupy a middle layer of decision making concerned with the structure of specific programs. The top layer of the hierarchy is controlled by provincial and federal government personnel, elected politicians and lawyers who control institutional management and the financial and legislative arrangements which guarantee the state's power to enforce institutional processes and practices. In today's economy, there is even another hierarchical layer of decision making control. International corporate interests, such as those that control medical insurance, seem to increasingly control government initiatives in health

services. These hierarchical processes of control are diametrically opposite to the horizontal processes of collaborative decision making in an ideal empowerment-oriented practice. Neither the decisions reserved for those at the top nor the differentiated organization of the hierarchy are open for collaborative decision making.

It is worth noting that hierarchical decision making is not unique to health services. The modern world is largely organized hierarchically from health services to religion to the military (Foucault, 1972; Giddens, 1984; Lukes, 1974, 1986; Smith, 1990). Hierarchical relations have become so embedded in society that examples of historical, collaborating societies are all but forgotten and are generally dismissed as inconsequential or even heretical (Eisler, 1988).

5.6 Summary

In an ideal empowerment-oriented practice, a core feature is that practice enables people to develop collaborative decision making partnerships with professionals. In essence, an ideal practice supports horizontal rather than hierarchical processes of decision making. Glimpses of this feature are present in occupational therapy literature and actual practice. These are important to note since they demonstrate small steps away from the tradition of professional dominance in health services. The literature shows occupational therapy's historical and contemporary practice of collaboration, particularly in enabling people to define therapeutic and personal goals which have purpose and meaning in their lives. Observation of actual practice shows occupational therapists encouraging people to make decisions about attending programs, defining goals, coordinating progress on their case, planning the day-to-day events of programs, and evaluating their satisfaction with programs. These glimpses seem most prominent in Site N. Here, the philosophy of psychosocial rehabilitation appears to structure possibilities which do not exist in programs which rely more on the philosophy of psychoeducation. What seems to make a

difference in collaborative decision making is that psychosocial rehabilitation conceptualizes people as active decision making members who have a stake in the success of the program.

Despite evidence that occupational therapy is not a typically dominant profession, collaborative decision making is controlled in all programs. Constraints which surround this feature all but submerge the potential for occupational therapists to enable people to be equal partners in all aspects of decision making about professional services and society. Contradictions, even in occupational therapy's talk and everyday interactions, show that this element of the vision has complex, far reaching tensions. People's mental difficulties in decision making and their reliance on professional expertise tend to undermine collaboration. But collaborative decision making is not merely constrained by everyday practice or people's mental limitations. Collaborative decision making is ultimately constrained by hierarchical institutional decision making processes. Institutional processes of decision making limit people from collaborating as decision making partners except in personal decisions and decisions to adjust existing programs. Out of bounds for collaboration are decisions associated with the institutional design and documentation of programs, including the documentary processes which make professional practice accountable primarily for the quality and efficiency of individual case management. Essentially, occupational therapy is accountable for controlling people's actions and the decisions which underpin case management. Although there is a growing discourse in favour of collaboration and partnership, hierarchical processes of decision making organize occupational therapy to control rather than enable collaboration

CHAPTER 6

SIMULATING REAL LIFE

6.1 Introduction

In addition to core features already described, an ideal empowerment-oriented practice is fundamentally educational in nature. The fourth core feature is that an ideal practice involves *educating people to think and act in the real world*. There are strong glimpses of this feature in occupational therapy literature and actual practice. In fact, real everyday occupations are both the process and outcome of occupational therapy (see 'OCCUPATION' DEFINITIONS', pp. xii-xiv). As a process, occupations are used as an educational medium. The desired outcome of occupational therapy is that people identify and achieve their potential to think and act in the occupations which have meaning for them in real life. Therefore, where practice reflects this philosophy, there are glimpses of occupational therapy consistent with an ideal empowerment-oriented practice. However, much of occupational therapy literature and actual practice show occupational therapy simulating segments of occupations in locations and time frames structured to represent real life in medical institutions. Chapter 6 analyzes how institutional 'program philosophy' and 'funding' processes organize the 'space' and 'time' structure for actual program activities. Moreover, the analysis shows how interconnections between program philosophy, funding, space, time and other institutional processes determine whether an educational practice merely simulates experience or enables people to incorporate learning into real life.

6.2 Grounding Education in the Real World: An Ideal Practice

Chapters 3, 4, and 5 have described three fundamental features in an ideal empowerment-oriented practice. Integrating these three features, an ideal practice recognizes people as equal partners who have the power to make decisions and to engage in individual and social action.

The fourth feature added in this chapter is that an ideal empowerment-oriented practice is fundamentally educational in nature. In particular, practice is grounded in real life so that education is oriented to people becoming empowered in the real world. An ideal empowerment-oriented practice engages active thinking people in learning how to transform real life to achieve empowerment (Freire, 1985). Furthermore, an ideal practice educates people to integrate critical reflection¹ with real individual and social action (Carr & Kemmis, 1986; Fay, 1987; Mezirow & Associates, 1990). Therefore, an ideal practice supports experiential learning, i.e., real action, where there is a cycle of reflection-in-action which has immediate relevance to individuals' real situations (Brookfield, 1987b; Kidd, 1973; Kolb, 1984; Tough, 1979; Welton, 1987).

To ground practice in people's real lives, an ideal empowerment-oriented practice uses 'enabling' forms and processes of education. An empowerment-oriented practice educates people through real experience which is relevant to people's real lives. Rather than limiting education to lectures or laboratory lessons², enabling forms and processes of education facilitate, guide, coach, encourage, support, prompt, stimulate, acknowledge and otherwise engage people as active

¹ The term 'critical reflection' has been chosen in keeping with the educational idea of reflective practice and learning (Kolb, 1984; Mezirow & Associates, 1990; Schon, 1983). For simplicity, 'critical reflection' is used synonymously with 'consciousness raising', 'insight development', 'reflection' or other terms which are specific to psychological, philosophical, social, feminist, theological and other discourses. The critical element is specified meaning that an ideal practice enables people to sustain an attitude of scepticism on historical and contemporary practices which shape power and empowerment.

² Lecturing and laboratory exercises engage real learners in real learning experiences but these experiences simulate real life situations through intellectualization rather than bodily engagement in the material world.

participants in the learning process³.

In addition, critical reflection is incorporated with real individual and social action. Therefore, an ideal empowerment-oriented practice is based on a two-part educational mission.

Responding to one part of the mission, practice educates individuals to critically reflect on and take action in real personal situations. The purpose of critical reflection is to develop ideas, values, beliefs, thoughts, reasoning, and real performance. For instance, practice facilitates listening so that individuals learn how distorted communication undermines individuals' power to interact as equal partners in the real world (Forester, 1980; Habermas, 1984). An ideal practice facilitates individual critical reflection so that individuals might undergo a 'perspective transformation' on their personal experiences of power. Practice educates individuals to see new meaning in real actions so that experiences of power in real situations take on a new 'meaning perspective' (Mezirow, 1991).

Integrated in a cycle with critical reflection, an ideal practice educates individuals to act by developing the skills required for everyday living in real circumstances (Collard & Law, 1989; Scott, 1992). By facilitating an integration of perspective and behavioural change, an ideal practice recognizes the empowerment potential of real bodily experiences derived from mental and physical competence (Fay, 1987; Smith, 1987). An ideal practice also grounds these experiences in the real situations where people live, work and play. An ideal practice may begin to facilitate critical reflection and action in simulated situations without the distractions and complexities of real life. However, education extends into real life situations to ensure that people's perspective transformation and skill development are transferred and incorporated into their real lives.

³ Enabling forms and processes of education are consistent with a person-centred practice since they recognize people as active participants with the power to influence their own learning.

The other part of the educational mission is connected with the first in recognition of the interdependence of individual and social action (see Chapter 4). An ideal practice involves facilitating, coaching or otherwise enabling people to step back to critically reflect on local and broad social practices. As an example, practice might initially educate people to 'codify' experience by simulating real actions in dance, pictures, role play, drama, music or other creative forms which bring power into view for analysis (Freire, 1985). By educating people to engage in codification, an ideal practice promotes "dialogic" processes of "conscientization" which help people to unravel the personal and organizational features which shape their lives. In other words, an ideal educational practice oriented to enabling empowerment may begin by facilitating critical reflection and simulated social action in supportive conditions away from the barriers they may encounter in real social action.

However, an ideal practice stretches education beyond codification and simulation of real experience. Practice also prompts people to transfer codified learning into real social action. This transitional education is where an ideal practice most clearly enables people to connect critical reflection and action in their personal lives with critical reflection and action in local and broad society. Overall, an ideal practice educates people to change real experiences of powerlessness which are socially organized by gender (Smith, 1987; Stanley, 1990), race (Pinderhughes, 1990), social class (Freire, 1972), physical disability (Zola, 1984), or mental disability (Rose & Black, 1985). Education is directed towards life long learning about the self and society (Miller, 1990). The aim is to educate people to develop understanding and action to enhance their empowerment in real life (Berger & Neuhaus, 1977; Cox, Erlich, Rothman & Tropman, 1979; Freire, 1973, 1976; Hall, 1981; Harding, 1987; Kieffer, 1984; Kilian, 1988; Lamoureux, Mayer & Panet-Raymond, 1989; Pinderhughes, 1990; Smith, 1990b; Sutcliffe, 1990; Wharf, 1979; Young, 1990).

6.3 'Learning Through Doing' in Real Occupations: Occupational Therapy Literature

When I analyzed the educational structure and content of programs described in occupational therapy literature, I found strong philosophic evidence of an ideal practice grounded in people's real life occupations (see 'OCCUPATIONAL' DEFINITIONS, pp. xii-xiv) (Reed, 1984). The profession has long emphasized the power of engaging in action in a broad range of occupations of everyday life as a means of influencing health. In occupational therapy, health has been broadly defined as the opportunity to find meaning and control in life through achievement of occupational potential. Therefore, occupational therapy's view of health is more than the absence of disease. Reilly's lecture, "Occupational Therapy Can Be One of the Great Ideas of Twentieth Century Medicine" (Reilly, 1962), Cynkin's text, "Occupational Therapy: Toward Health Through Activities" (Cynkin, 1979), and Kielhofner's text, "Health Through Occupation" (Kielhofner, 1983) are leading works which articulate occupational therapy's interest in occupation as both the process and outcome of this health practice.

The philosophy of engaging people in real occupations appears to underpin a small proportion of practice. Historically, occupation workers involved people in the full range of real occupations required to operate the asylums and other institutions in which people were housed (Reed, 1984). 'Occupation workers' (males and females) engaged individuals and groups in ordinary activities which might demonstrate their suitability for release from the confinement and segregation of asylum life and display their potential to contribute in some real meaningful way as valued members of society. Today, approximately 20% of practice in Canada occurs in real life situations such as homes, schools, work places and various other community locations (Canadian Association of Occupational Therapists, 1993b). There are reports of occupational therapists in these settings engaging individuals and some groups in real individual and social action (see Chapter 4.3).

However, analysis of occupational therapy literature shows tensions related to this feature. Although occupational therapy philosophy directs therapists to enable action in real occupations, there is a tremendous emphasis on simulating real life. While historical records show a few occupational therapists engaging people in real occupations, hospital-based practices have been restricted since the turn of this century by labour laws (Driver, 1968). Hospital-based practices were reduced to using occupations which could be simulated in hospital facilities without competing with union labour. "Occupational work" became confined largely to those handicrafts which could be conducted within "occupational rooms" (p. 54), particularly within tuberculosis sanatoria. The move to occupational rooms also narrowed the scope of practice by segmenting occupations into chunks which could be accomplished during designated time segments in hospitals (Clark, Parham, Carlson, Frank, Jackson, Pierce, Wolfe & Zemke, 1991). Occupational workers no longer structured routines which shaped a real meaningful daily or yearly existence (Peloquin, 1991). At that time, the overriding images in literature and photographs are of occupational therapists adapting almost every kind of personal care, work or recreation activity to enable individual action in hospital beds and occupational therapy rooms. Occupational therapists became highly skilled, particularly in long term institutions, at constructing special equipment and developing techniques for people immobilized by body casts, slings, paralysis, amputations or diseases such as tuberculosis. Special equipment and techniques were used to engage people in eating, bathing, painting pictures, light carpentry, cooking or any other piece of an occupation which simulated some part of real life. These pieces of occupations had typically been analyzed and adapted to reduce pathology associated with some type of illness or disability in medical settings.

Even today, approximately 80% of occupational therapy's work is in the simulated situations available in health settings (Canadian Association of Occupational Therapists, 1993b).

Virtually every journal has advertisements from companies selling equipment to simulate kitchens, bathrooms, work environments and so on in occupational therapy 'departments' in hospitals or other centres. A prominent 1990's advertisement is for "Our Town", a simulated community for institutional settings. Although the community is extolled as a practice site which "deinstitutionalizes" occupational therapy into real life situations (Dasler, 1984; Devereaux, 1991; Townsend, 1987), neither historical nor current literature show evidence that occupational therapists are challenging the limitations of hospital conditions for grounding practice in people's real lives. The majority of practice has been structured for so long in hospitals and other health settings that tensions around engaging people in simulated versus real occupations seem to be taken for granted. Instead, occupational therapists have perfected the art of simulation.

In the literature on 'psychosocial' or mental health practice, descriptions of occupational therapy practice in psychosocial rehabilitation programs show the greatest attention to enabling people to engage in real life situations. Articles refer to educating clubhouse members to develop skills to budget money, shop, use transportation, look after an apartment and so on in real life (Krupa, Singer & Goering, 1988). But, the overwhelming majority of reports on mental health practice emphasize paper and pencil, role play and other simulation exercises designed to develop people's self esteem, cognitive function, emotional expression, non-verbal communication or other psychological traits.

6.4 Stretching to Include Real Life Education: Glimpses of the Ideal in Occupational Therapy Practice

While the majority of reports on mental health practice emphasize simulation exercises in simulated environments, this study indicates that actual practice is somewhat grounded in people's real life experience. Analysis of the educational structure and content of programs

suggests that some elements of practice include critical reflection and real action.

I analyzed the educational structure of the seven programs in this study by examining where practice occurs and what program activities occur over time. In other words, I traced the ways in which 'space' structures programs from a standpoint in actual practice. From this standpoint, I noted the actual locations, facilities and equipment of everyday practice. Analysis of the space used by programs not only reveals whether people are 'active' or 'passive' (see Chapter 3), but also whether programs emphasize simulated versus real use of 'space'.

As well, I analyzed how 'time' structures programs by examining the schedules of actual activities. In Chapter 3, I introduced program schedules to show that people are expected to be active participants in programs (see Chapter 3). Schedules were again presented in Chapter 4 to show how practice emphasizes individual case management even though schedules appear to provide a fairly even amount of time for individual and group activities. In Chapter 5, I indicated that schedules include planning time in which people collaborate in structuring specific program activities even though they are excluded from decision making about the overall structure of mental health programs. In this chapter, I return to schedules to analyze the simulated versus real structure of program time.

How real is the structure of program space, meaning the locations, facilities and equipment used by occupational therapy in these programs? The four programs located in hospital settings (Sites B, C, P and R) are in general, not psychiatric, hospitals. In each site, programs are located away from in-patient wards. They occupy a floor, a wing, or a set of rooms which distinguish the space as a separate unit. Access to the four programs is not direct from outdoors. People have to go through other hospital sections to reach the program area. The location of mental health programs in general hospitals contrasts with old style psychiatric programs which were often built to simulate community life with residences, farming, small

industries and other self-sustaining activities separate from any real community (Dunton, 1919). The other three programs (Sites J, M and N) are in real houses in or near real residential areas. These programs are all accessible by ordinary public transportation including buses and taxis (although these are not always convenient to use). These are 'town' programs, none being part of the fishing, farming or logging communities common to Atlantic Canada. The programs in general hospitals are part of the real community, although it is stretching reality to think about hospitals as part of real life. However, Sites J, M and N are part of at least some people's real communities since the houses look like other houses in their district.

All seven programs have facilities and equipment which more or less resemble the real homes, recreation areas, and workplaces of at least some people's real lives. All programs have some facilities and equipment for talking with people. There are also various combinations of kitchens, lounges, various types of workshops, washrooms, handcraft areas, recreation rooms, clerical work areas, maintenance storage areas, halls with and other equipment where people can engage in real action.

How 'real' is the structure of 'time' in these programs? In Sites B, C, P and R (in hospitals), a published, weekly schedule outlines how program sessions are structured over time (see Table 12). However, as initially observed (see Chapter 3.4), all programs typically operate from Monday to Friday. They tend to start at 9:00 AM and finish at 3:00 PM. Occupational therapists typically work from 8:00 or 8:30 AM to 4:30 or 5:00 PM with considerable flexibility by including some evenings and weekends to respond to changing program events and the specific needs of people⁴. There are breaks mid morning and mid afternoon with an hour for lunch. As well, depending on the type of space (see Chapter 3.4 and above), time is also scheduled for real

⁴ The occupational therapists in all sites fill day time positions covered by hospital (or government) and union agreements. Overtime is informally organized without salary adjustments.

action, including meal preparation, recreation, handcrafts, outings, "doing for others" and involvement with various parts of the community. For instance, people become involved in decorating and cooking for Christmas, and special meals for other events. Some planning time is connected with these real actions as people plan the real menus, shopping, and schedules associated with these events.

In contrast, there is no published schedule in Sites J and N. However, there are regular events (see Table 12). As an example, Site N includes a daily check-in group meeting⁵. But the vast majority of time is spent in the real occupations which form the core of these programs: food services, clerical work, and maintenance. More than in the other sites, time is spent in planning and conducting these real tasks. People shop in real stores and cook, set tables, wait on tables, clean up, and check supplies associated with the real events of coffee breaks and lunch. Those doing clerical work do the photocopying, collating, typing and other clerical duties required by these programs. Maintenance work includes painting, lawn mowing, snow shovelling, repairs and other duties which keep up program houses. Other occupations include gardening, recycling or mail duties which contribute to the running of the program. In essence, time is organized to provide an educational program content based on the real routines and tasks of self reliance. As well, Nora and Jill, the occupational therapists in these sites, involve some people in real public processes such as exerting their rights to vote and speak publicly about transportation, job training and other issues which effect them as citizens (see other examples of social action in Chapter 4).

There is no fixed program schedule in Site M since the work consists primarily of individual counselling and a variable schedule of group work. However, May involves people

⁵ This group is also analyzed as evidence of group work in Chapter 4 and as a decision making forum in Chapter 5.

in real life education through wide ranging consultation and community workshops.

In all programs, occupational therapists engage people in real community situations through recreation (e.g., swimming, badminton, bowling). They also use 'outings' to go to malls, or places of interest like a museum or radio station. Real situations are viewed, in part, as an assessment opportunity, as Pat describes.

I think of the times, say we've been on an outing, and we're coming back, and I'll say to somebody, 'boy, did you see how so-and-so participated, or did you see what so-and-so did or said to me?' or whatever I think is a reflection of whatever difficulty they've come in with. Whereas, at other times when I've done a group on self-esteem or assertiveness or whatever, we often find we're not coming out of that group any more enlightened about people. Or without having offered them any more than when they went into it. (Interview with Pat, PINTOT08, 1080-1096)

Pat indicates that seeing people in real situations makes her "more enlightened about people".

In part, however, real situations are seized as real opportunities to facilitate learning relevant to the moment as Jill describes. The lesson is how to use a phone book.

I see myself as a teacher. But not in the formal sense. By taking advantage of an opportunity as it arises, it can be a very spontaneous thing. Sometimes you might have a set schedule to teach somebody something. But if someone comes up with a problem of, for example, they need to contact somebody. I would naturally capitalize on that. And say, 'here's the phone book'. And they might say 'you call'. And right away, I'll say, 'no, I won't. Ok, can you look up the phone book. Here's how you do it'. So, I think in very, everyday, situations we capitalize on those opportunities. And they are often the best ones. They are the ones that are important to that client at the time. If I sat down with that client the next day and said 'here's how to use the phone book', he'd say 'right, I've got better things to do'. (Interview with Jill, JINTOT01, 1405-1429)

Furthermore, occupational therapists go to people's real homes and community situations to educate them in the instrumental skills of community living. As Jill says:

If we need to tutor their ability to function in the house - learning how to use the washer and drier or something like that - something more lifeskills or community living skills related - for example using the bus - we would actually go out and do that. (Interview with Jill, JINTOT01, 742-750)

Table 12

Core Curriculum: Interactional and Occupational Sessions*

	Interactional	Occupational
Site B	Personal Growth Life Skills Group Therapy Stress Management Communication Group Assertiveness Training Individual Sessions	Group Meal Activity (Handcrafts) Lunch Preparation Recreation Individual Sessions
Site C (1/2 day program)	Verbal Group Stress Management Individual Sessions	Activity (Handcrafts) Bowling Individual Sessions
Site J	Individual Sessions	Life Skills Work Skills Work Therapy Outreach Work Therapy Hospital Industries Handcrafts Recreation Outings
Site N	Personal Effectiveness Training (P.E.T.)	Food Services Clerical Maintenance Recreation Outings
Site P	Group Therapy Creative Expression Life Skills Values Stress Management Individual Sessions	Cooking Activity (Handcrafts) Lunch Preparation Games (Friday Group only) Music Outings Individual Sessions
Site R	Health & Lifestyle Stress Management Assertiveness Training Individual Sessions	Aerobics Doing for Others Aquacize Individual Sessions Community Day

* Table constructed from weekly schedules and observation notes. There is no 'program' schedule in Site M

In comparison to health practices where professional time is a series of scheduled appointments for care, special tests, consultation or counselling, people's use of time in these programs is typically structured as a real five day-a-week, day-time job. Individuals and groups are engaged in at least some real occupations including those through which people look after themselves, enjoy life and make some social if not economic contribution to society. People complete real projects related to special events. Or they do the real work of feeding people and looking after the clerical and maintenance work which has a real, meaningful function in operating a program. Thus there are clear glimpses of occupational therapy practice in which people are engaged in real life occupations.

6.5 Emphasizing Simulation: Distorting the Fundamental Purpose

Despite some evidence that occupational therapy uses space and time to engage people in real occupations in what resembles a day-time work day, practice occurs within programs which structure space and time like a standard school - a series of classes separate from real life and occurring during the day time hours which correspond with a business day and teachers' contracts. This separation from real life means that tensions surround both the structure and content of practice. Despite its philosophy, occupational therapy operates in space and time conditions which are structured to favour simulation.

It is important here to highlight that people who attend these programs have difficulty living real life. Given that real life is the problem, there is value in at least temporarily simulating real life in a protected, safe environment with sympathetic group members and professionals⁶. In fact, programs are classified as "transitional". Therefore, their purpose is to offer transitional learning which is, as Carol says:

⁶ The supportive 'inclusiveness' of day programs is analyzed more fully in Chapter 8.

a sort of transition point between being in hospital and being functional again in the community. (Interview with Carol, CINTOT02, 33-35)

Programs function as a bridge which Carol describes as touching both hospital and everyday life. Therefore, one might expect a graduated shift from simulation to real action. However, in some policy documents, these are also described as "partial-hospitalization" programs. The title suggests that programs are not actually a bridge but a mechanism to reduce the costs of hospital services. It appears that this transitional practice is institutionally organized to simulate life as an alternative to hospital care rather than to educate people to change powerlessness in real life.

Occupational therapy job and program descriptions do not restrict occupational therapists from practicing in real community situations (see Chapter 4.4). However, during my 74 days of observation, I saw only four visits to personal residences or group homes: two each in Sites P and R where I spent eight and six weeks respectively. As Nora says:

One of the things that might interfere...with the notion of empowerment [pause] is the connection with the hospital. I think that's something. Because that keeps you quite attached to the medical model although you're trying to work with something that's very different. (Interview with Nora, NINTOT02, 7789-797)

While practice occurs in real kitchens, workshops and so forth, the location, facilities and equipment are all simulations of people's real life circumstances. As well, simulations are structured to represent only a small segment of real life. These segments are relevant to the real lives some but not all of the people who attend these programs. As Nora says, the structure is determined by the program connection with hospitals which operate from a "medical model". As she highlights, "you're trying to work with something that's very different".

Not surprisingly, then, the tensions of simulating people's real lives are particularly great where programs are located in hospitals. For instance, in Atlantic Canada, occupational therapists work with some people who are from rural areas where home life includes wood and oil stoves and where recreation and work are done in the woods, open fields or water. Other

people live in urban areas in conditions ranging from expensive homes to boarding homes where they cook on hotplates. Clerical, woodworking, cooking and maintenance equipment are not necessarily real to the work situations which some people face in real rural or urban situations. While space is structured to resemble real life, occupational therapy in transitional mental health programs is situated in a single location. Facilities and equipment reflect a singular version of real life. Although occupational therapists attend to people's real lives, they do so by simulating some versions of reality. As Bev says:

[a lady we had been discussing] needs to practice being in a social situation - going out in the community and actually looking for work. I can practice it in here till the cows come home. But I can't go out there right now. Or maybe we need another occupational therapist whose job is community work. (Interview with Bev, BINTOT02, 328-336)

Furthermore, occupational therapy operates within a curriculum which resembles a five-day work week. The 9:00 A.M. to 3:00 P.M. schedule represents a real work schedule for some people, but certainly not all. A regular, day time, five-day structure is not real to homemakers, parents, shift workers, self-employed persons who determine their own hours, or volunteers who respond to people's needs at various hours. As well, the time schedule resembles a work day but many people raise problems related to personal care, leisure and general community occupations which occur at various times of the day or night. In essence, time, like space, is structured to represent only a small segment of real life for only a segment of people.

Why are space and time structured to simulate singular versions of real life? And how are the glimpses of attending to real life sustained within this structure? Given that occupational therapy is aware of the importance of attending to people's real lives, why does the profession emphasize simulation over real life? Specifically, how is the emphasis on simulation in everyday practice embedded in institutional processes?

To address these questions, I trace this feature of practice to two institutional processes:

program philosophy and funding. I look at the institutional organization of practice based on psychoeducation and psychosocial rehabilitation, the two main philosophies shaping the educational structure and content of practice in this study. Although sites generally displayed some elements of these two and other philosophies, each emphasized one of these two.

The philosophy of psychoeducation, prevalent in Sites B, C, M, P and R, structures programs around ideas and beliefs that psychological education can enable people to better attend to their own mental problems. Psychoeducation educates the psychological 'case' constructed by the psychiatric diagnosis of patients (see Chapter 3.5). As the name implies, psychoeducation focuses on educating people about psychological processes and their influence on behaviour. Psychoeducation promotes an intellectual form of learning through simulation of the real behaviour associated with interpersonal and group interaction and personal growth. As well, as Rita says, there is a tremendous emphasis on providing information:

...tend to think of information as empowering. So the more information on assertiveness or stress management a person has, the better. (Interview with Rita, RINTOT08, 570-574)

Of interest in this chapter, the most prevalent sessions in Sites B, C, M, P and R, are shown to be those listed in Table 12 as 'interactional'. These are individual and group sessions in which psychological learning is promoted through interactional, intellectualized simulations of real life. In other words, the simulations often refer to real life.

This means that there is an interplay between attending to people's lives and using methods which simulate real experience within the space and time structure of psychoeducation programs. The educational content consists of exercises such as role plays and pencil and paper exercises in which people are asked to interpret psychological processes or demonstrate behaviour in imaginary or remembered situations. Examples of interactional sessions include Personal Growth, Life Skills, Assertiveness Training, Stress Management, and Communications. The

translation of learning from simulated to real life experience and situations is left to the person. To illustrate how psychoeducation shapes an interplay between attending to people's lives yet uses methods which simulate real experience, I will summarize typical sessions with individuals followed by a summary of an "Assertiveness Training" session.

With individuals, as Carol describes, she engages people in occupations ("activity") as a "measuring stick" of people's psychological progress.

I always explain the use of activity as a kind of measuring stick that they can utilize to determine if their medications are helping - if their concentration is improving or if they are beginning to even feel like coming to activity. I explain that at first, you don't even feel like you want to come. Then you'll be able to come for 10 minutes. Then you'll notice that you can do 15 minutes, then 1/2 hour. So that they can use it. I try to give them control and help them to see how they can use it. And then that's followed up by our activity laboratory questionnaire - that I showed you - where they sort of score themselves on how they are improving in activity. And then, from there, get them involved. I've managed to refer just to get some involvement in the community. (Interview with Carol, CINTOT01, 235-257)

Carol does not indicate whether she facilitates critical reflection or whether she enables the person to integrate this real experience with "activity" in real life. Instead, "activity" is not only used as a medium for assessment (see Chapter 3) but as a medium for enabling people to develop psychological traits such as "concentration", being able to "feel like coming to activity" (which might be related to psychological motivation), and tolerance, that is, being "able to come for 10 minutes. Then you'll notice that you can do 15 minutes, then 1/2 hour". She is engaging the person in real action in real time. But she appears to be using "activity" to engage a person in some action which may or may not be relevant (the relevance of "activity" is not stated) in order to develop concentration, motivation and tolerance in a hospital context separated from real life. The attention is on psychological processes more than real life action.

We have already seen another example of the interplay in which real life is simulated: Rita facilitates Brenda's reflection on her real life which includes "take medication" (see Chapter

3.5). However, to get this information, Rita asked Brenda to simulate her weekly activities, i.e., artificially represent her real life on paper by filling in a sheet drawn with seven columns, three sections to a column, to represent morning, afternoon and evening segments of the week. Paper and pencil exercises which create lists, charts, diagrams and other forms of visual representation of real life are commonly used to develop visual simulations of time (schedule sheets), space (drawings of home or community situations), relationships (drawings of people in real situations), or emotions and thoughts (symbolic drawings). Occasionally occupational therapists also facilitate reflective thinking by asking people to simulate feelings or ideas through creative media such as clay, art, dance or music. These simulations provide objects for reflecting on real life while separated from real life circumstances. In themselves, these approaches are somewhat consistent with an ideal practice since they generally enable critical reflection on real life. They are forms of codification which enable people to visualize their real lives and stimulate the dialogic processes required for conscientization (see Section 6.2). However, they do not transfer codified learning into action in real situations.

A similar interaction between real experience and simulated learning exercises occurs in group sessions such as one on assertiveness observed in Site R. The process proceeds through steps summarized as:

1. reviewing concepts of assertiveness (by staff member or by asking for ideas from the group)
2. each group member in turn discussing a specific situation during the past week (where they felt angry, helpless, frustration, impatient, overlooked, overwhelmed, bored, scared, punished, criticized unfairly, etc.)
3. each group member engaging in a role play to recreate the situation as it had occurred
4. discussion of assertiveness issues as group members see them, with ideas contributed by staff
5. re-creation of the role play following guidelines for being assertive

6. definition of a behavioural objective for practising assertiveness over the next week (sometimes called "homework") (Extracted from observation of Rita, ROB19, 111-631)

One variation is that the group works with a particular theme or emotion rather than each person raising a different situation, and only those who volunteer actually engage in role plays. For instance, the theme might be 'frustration' and each group member defines a real situation in which frustration has been or continues to be experienced. People role play remembered then revised versions of real frustrating situations in the simulated conditions of programs and with group members who are not the real people involved in the frustrating situation.

While psychoeducation programs emphasize the dialogic forms of codification which are consistent with an ideal empowerment-oriented practice, real action is largely represented by role plays removed from people's real situations. The situations are themselves a representation of real events as remembered. This is an important step in education since role plays do address people's real situations. In fact, I observed 'Andrea', a person in the assertiveness group, commenting on the importance she places on the program linking reflection to real life:

I had been through assertiveness and stress management groups on the in-patient unit. But I must say I found that I've learned things in the groups here. You do them differently. And you run and approach these groups differently. I found that I learned quite a few things. I really learned things that were practical for my life. ('Andrea', a person in Site R, ROB17, 660-669)

The analytic point here is that role plays may address people's real life situations, but they are based on interpretations rather than shared, real experience. No other group members were present in the real situations so that they can not respond to people's real situations. They can only respond to people's interpretations of real situations in a different context. Conversely, group members transfer learning from the group to real situations. However, what enters and leaves these sessions is a remembered, interpreted version of real life and a memory of real role play situations. These multiple realities are not brought together in the same space and time. Furthermore, the main interpreter is a person who has been diagnosed with a mental disorder

because of mental difficulties in managing, perceiving or interpreting everyday life.

Of key importance, professionals and other group members are absent in the actual transition between real and simulated space and time. They can neither corroborate nor refute interpretations which people have made as they attempt to translate their learning from simulated situations in the program to real life.

If we follow Rita's goal setting and coordination with Brenda (see Chapter 4), we can appreciate that Brenda's weekly goals are real to her: do laundry, do dishes nightly, cut friend's hair. However, Rita prompts Brenda to translate these everyday life goals into assertiveness goals using the general format for setting assertiveness goals in psychoeducation programs. Therefore, Brenda defines her assertiveness goals as "making positive statements" and "giving compliments". In the group, Brenda is asked by Rita to reflect on the "homework" she chose in the previous week to address assertiveness goals. She reflects on a goal defined as "making requests".

Rita: Have you been making requests?

[NOTE: Brenda's "homework" was to "make one request per day" defined by the therapist from her discussion last week about her difficulty speaking up and asking for help when she felt overwhelmed and the feelings grew into helplessness, panic, mania and hospitalization]

Br: I don't know. I guess I made a request to my son. I asked him to clean up the living room. And I was just amazed he did it in no time. I gave him a compliment and said thank you. (As Brenda talked, her face became more and more animated. She smiled and leaned forward in her chair. She had more expression. Her voice was stronger) He comes in the door and just throws everything down, his school bag and everything. You come directly into our apartment into the living room and he treats that like his own room. I guess that's like any teenager. I said to him 'I'm just looking around this room. Are you looking around too? Are you going to clean it up?' He said ok and had it done in a few minutes.

Rita: It sounds like you did your homework after all. Now what would you like to try this week? (Observation of Rita, ROB19, 254-280)

Rita does not attempt to facilitate real action. Rather, she teaches Brenda to reflect on her real

life in a location separate from real life. She also teaches her to think about her life using the behavioural definitions of assertiveness used in psychoeducation. Therefore, Brenda is developing skills to reflect on her behaviour in real life and to engage in new psychologically-defined behaviour within the simulated conditions of the Site R.

Rita did visit Brenda's home on one occasion. But most of the transitional learning was left for Brenda to do on her own without Rita's guidance. As she role plays making compliments in a group session, Brenda makes real compliments to real people sitting in the group. But these are not the people Brenda faces in her real life. The role plays are an intellectual interpretation made by Brenda and those who hear her story. They are abstract, reasoned versions of what really happened and might happen when Brenda is in a real life situation. As Brenda participates in recreation, she is encouraged to make compliments and requests so that the idea is integrated with real action. Once again, the swimming and aerobics which Brenda does for recreation in Site R are real but they are not what she does in her real situation. These activities may teach her to enjoy such recreation and plan to include it in her real life. But, she is still left to translate that experience into her real life without the same intensity and sophistication of guidance provided by health professionals for the intellectual part of her learning.

This analysis displays another piece of the ideological circle of case management (see Chapter 4.5). The emphasis on simulation is organized by ideas, values and beliefs about the psychological education of mental cases. Case management is based on the creation of mental facts which are first interpreted as diagnostic categories (see Chapter 3), then shaped into another set of facts called goals. Goals interpret lived reality in terms of mental constructs such as assertiveness, stress and so on (see Chapter 4). In this chapter, we can see that simulation exercises, such as role plays and paper and pencil exercises, organize institutional explanations and action to change people's reality using mental goals as an interpretative framework. The

framework authorized to justify and organize this practice is the philosophy and practice of psychoeducation. In other words, the authorized educational practice is one which simulates life experience as a method of educating individually diagnosed cases to demonstrate change in goals. The circle is completed by using textual facts about progress on goals to demonstrate the quality of practice.

In contrast with psychoeducation, the philosophy of psychosocial rehabilitation⁷, prevalent in Sites J and N, structures programs around ideas and beliefs that psychological difficulties are connected to real life experience⁸. Psychosocial rehabilitation is a broad term which encompasses the Fountain House Model, the Clubhouse model and other approaches which structure education by defining goals and coordinating action within a system of individualized case management (Beard, Propst & Malamud, 1982; Berry, Carver, Gayler, Loewen, Murphy & Parkinson, 1988). Clubhouses developed to offer a membership experience to those whose mental disorders have been long lasting (more than a few years). The philosophy takes into account that people are struggling with real life difficulties such as poverty, a poor employment history, limited skills for employment and general living, a very limited network of social support, and social stigma against having them in housing or recreation in local neighbourhoods⁹.

⁷ Psychosocial rehabilitation's conceptualization of people as clubhouse members who are collaborative decision making partners in planning at least the everyday aspects of programs has already been introduced in Chapters 3.4 and 5.4 respectively.

⁸ To me, this philosophy is derived from ideas, beliefs and values which mirror those historically held by occupational therapy. Other professions, primarily nursing, psychology and psychiatry, have formulated these ideas into a philosophy which is getting international recognition whereas occupational therapy continues to be uncertain itself and unknown to others. Nevertheless, occupational therapy has become a strong advocate of psychosocial rehabilitation citing its strong compatibility with occupational therapy's interest in people's real lives (Krupa, Hayashi, Murphy & Thornton, 1985).

⁹ This summary is highly simplified. In actual practice, there are many versions of psychosocial rehabilitation. Some are highly behavioural with organized schemata for the incremental development of skills. Others stress the "clubhouse" element. Still others stay truer

As a result, programs which are based on the philosophy of psychosocial rehabilitation are grounded, as much as possible, in real situations. Evidence of this can be seen in Table 12 which shows Sites J and N (adhering generally to psychosocial rehabilitation) emphasize occupational over interactional sessions. In these sites, the program content is weighted away from simulation exercises and discussion and towards real cooking, house cleaning and maintenance, telephone reception and message taking, basic clerical duties, and basic employment skills in industrial sub-contracted work projects such as re-cycling and packaging. These occupations are real in that people are handling real materials which they fashion into real products. They are in locations which look like real houses. However, tensions exist where action occurs in facilities and with equipment which simulate a singular version of real life. To illustrate, I observed Nora working with 'Hal' around meal planning, shopping, kitchen organization and cooking:

9:22 A.M.

Nora asks Hal who is chef for the day to sit down in the dining area to go over the menu for the noon meal before they go shopping and before Hal talks to the other people he will be directing that day in the kitchen.

Nora: I've changed your menu here...I've substituted mashed potatoes for the rice and cottage cheese for the hard cheese in the salad in order to cut costs ... because our costs are getting up there... 'sometimes with a menu like this we have to compromise one thing for another so since you have pork chops, I took off the cheese and rice'...this is a very good menu...what you need to do now is fill out the tasks on the back cause you'll be running the meeting to help the rest of the group get organized in a few minutes...so what tasks need to be done? (Hal took the sheet and pen and started to make a list) you're right (when Hal wrote down 'make bran muffins')...then what else (Hal said 'make port chops')... yes, that's right, but you can break it down so that you put here that someone browns the pork chops and puts on sauce because then we'll do them in the oven...(Hal put down 'potatoes after the break). (Observation of Nora, NOB01, 244-274)

to the original Fountain House Model. Site N, in particular, has incorporated some of each of these approaches into a unique program which is highly community-based, with vocational, housing and other elements of real life. (Interview with Site N psychiatrist, NINTPC, 98-264)

Hal and others are preparing for a real meal. Nora facilitates real action by helping Hal to plan to take on real supervisory duties. The action itself is real rather than role played. Reflection is elicited during conversations with Nora asking Hal questions such as 'so what did you think of that?' and 'what do you need to know to live on your own?' 'Where will you get money to support yourself?' Questions elicit reflection on everyday life in which real action is taking place. Through such sessions, people, like Hal, are encouraged to think about practical relevant conditions while they are engaged in the same type of real action.

Nevertheless, analysis of situations like the one described with Hal indicates that, like in programs based on psychoeducation, there is an interplay between attending to people's lives and using methods which simulate real experience within the artificial space and time structure of programs. The interplay is different since the experience is far more real than in psychoeducation programs. But the space and time conditions are still simulated. The action does not occur in Hal's real apartment. Action occurs in the simulated kitchen of Site N. While the cooking and kitchen are real, Hal's boarding house kitchen has far less equipment and supplies. He will also be managing on a far stricter food budget than is available in mental health programs. People are learning to make nutritious food. However, the pork chops and muffins may still be beyond the budget or cooking conditions which people like Hal face at home.

Therefore, engagement of people in cooking and other real occupations makes psychosocial rehabilitation programs appear to attend to real life more directly than the simulation role plays and so forth in programs based on psychoeducation. But, engaging Hal and others in occupations such as meal planning and preparation is, in essence, another version of using role play to simulate real experience. Hal, like Brenda, is translating reflections from his home experience into action in the program facility. Just as Rita visited Brenda's home to see her real sources of frustration, Nora has visited Hal's place so can corroborate some of his interpretation

of working in the conditions in his kitchen. Nevertheless, for the most part, Hal is left to interpret, translate and transfer simulated learning to and from his real situation since he rarely works with Nora's guidance on location in his apartment.

To analyze the tensions around grounding practice in simulated versus real action, I began by tracing the structure of space and time to two types of philosophically-grounded programs. But the structure of space and time can also be traced to program funding. To illustrate this connection, I will show how budget categories, petty cash and revenue generation processes organize programs to emphasize simulation over real action regardless of whether the philosophy is psychoeducation or psychosocial rehabilitation.

First, budget categories and the general percentage of funding allocated to budget lines indicate funding for salaries versus equipment and supplies. Approximately 97% of transitional mental health program funding is for salaries. Salaries pay for a single team which operates during day time hours. There is no funding for other teams which might work early in the day or late in the evening or in real community situations. Therefore, practices which are grounded in real situations must be covered by staggering the work schedules of existing team members, by providing time off in lieu for overtime work, or by asking staff to volunteer time. Not only do salaries structure staff time but they structure program possibilities. There are almost no funds for the actual program. All programs include a budget category called 'occupational therapy supplies' or 'activity supplies'. Some include a category for 'outings' or 'recreation'. However, the amounts are all a division of the 3% or so allocated for non-salary items. Together, occupational therapy supplies and recreation/outings budget lines generally hover around a few thousand dollars per year. The presence or absence of 'occupational therapy supplies' in a budget, however, can be misleading. Site N for instance, does not include occupational therapy as a budget item but rather funds materials as a fundamental structural

requirement for the program.

Another funding mechanism is petty cash which tends to operate as a separate budget envelope from that for salaries and supplies. In all programs, the occupational therapists use petty cash to purchase real activity supplies or even to invest in materials through which they generate small amounts of revenue. This is particularly true in Sites J and N where food, craft and other products are made for sale (see the analysis of revenue generation below). However, in hospital-based programs, occupational therapists use the hospital purchasing system where policies, such as those in Site R, indicate that they are not to resort to petty cash:

Food required for patient treatment programmes may be requisitioned from the Food Services Department.

If therapeutically appropriate or if foodstuffs unavailable from Food Services, items may be purchased outside.

Staff requiring bus tickets for business or patient programmes must obtain authorization (Policy and Procedure Manual, 1989, Site R)

The general policy is to use the specialized buying and transportation systems organized by hospitals. These policies may increase efficiencies in using bulk orders which reduce the costs of supplies. But, they reduce the potential for people to learn to budget real money and buy food in real stores. Despite the presence of policies for using institutional resources, each program allocates from \$50 to \$200 per expenditure of petty cash to purchase real food, handcraft and work supplies, and to subsidize outings in real situations. Therefore, petty cash provides flexibility and spontaneity for real community experiences. But the funding for this type of work is minuscule. Given this limited financial support, possibilities for real action are small scale. As Pat says, petty cash allows people to do a few ordinary things in the community like going out for a meal or bowling:

Three to four dollars per person for a meal out - equal to meal tickets in the cafeteria - 'I ask for \$30 for groceries and \$20 for an outing unless I know it will be more or less expensive....[re outings] when we started, we tended to do a lot of bowling which is more costly but we've been doing trips which are cost free like the radio station'...We've had suggestions that we go horseback riding. But at \$10 - 12 per person, what we do is say to people that's beyond our budget, let's try to do a fund raiser if you want to do something special like that....I don't have any written guidelines but anything that's in excess of \$5 per person, we'd have to think about or do some supplementary fund raising. (Interview with Pat, PINTOT02, 181-233)

In some programs, the standard budget includes very few materials so that petty cash, and just plain scrounging as I observed in Site B, are used to provide opportunities for engaging people in real handcrafts:

Projects are chosen by the occupational therapist and occupational therapy assistant if they require very little material, can be completed within varying levels of skills, and are designed for short term completion. The assistant chooses things from craft catalogues and orders the materials so that inventory, to a large degree, determines what activities are available to do ... they use local, donated materials where possible. The wood is donated from a construction company where a relative of a staff member works. The wood burning frames use this moulding from the same company with some donated stain. Another project uses local riftwood sanded & stained. The occupational therapist found an old radio in response to patient request. (Observation of Bev, BOB01, 641-664)

Scrounging may be the real life experience of acquiring educational resources in even the most empowerment-oriented practice. Therefore, low cost ventures which depend on scrounging may actually provide glimpses of possibility for enabling empowerment. Nevertheless, it seems clear that institutional budgets and policies only support practices which can operate on a shoestring with very little funding other than for professional salaries.

The third funding practice described here is revenue generation. Six sites allow for revenue generation through the sale of goods in controlled circumstances (excluding Site M). For instance, in Site R, program policies concerning funding state:

Patients may be charged for materials used in therapeutic projects.

Partial hospital patients...must be discouraged from raiding the department's supplies and encouraged to go into the community to make their own purchases.

Tools and equipment may not be sold to patients (this includes rug hooks, tape measure, needles, etc).

Amount charged for articles is at the discretion of the staff member responsible for the patient concerned, or for making the sale, as appropriate.

Special funds for specific projects or programmes may be set up from time to time.

Sales are limited to the price of supplies. Occupational therapists have freedom to set prices, although there is usually an administration-approved list which standardizes prices. Projects are restricted from competing with real community businesses (see Chapter 8).

Together, budget categories which include occupational therapy or activity supplies, petty cash and revenue generation interact to fund more simulation than real life experience in programs. However, it is interesting to see that these same processes actually support the glimpses of practice grounded in real life. They provide at least a small funding base for enabling people to incorporate critical reflection with real action. These processes explicitly support the costs of real materials, local transportation and participation in community events. In fact, I would go so far as to say that an occupational therapy/activity budget line, petty cash and revenue generation constitute occupational therapy's 'stamp' on programs¹⁰.

While these three funding processes support the glimpses of practice based on real life, they are marginal to the overall funding of mental health programs. The 'occupational therapy supplies' item is almost a miscellaneous expense (and is even itemized as such in some situations). Petty cash is just that - petty amounts of money which can be used at the discretion

¹⁰ This claim is speculative and rather arrogant. Certainly, other team members have an 'interest' in people's real lives and support budget allocations for the equipment, materials, supplies, transportation and other costs required to engage people in real action in real community situations. However, occupational therapy's explicit interest in occupations seems to be most clearly associated with funding mechanisms for real life action.

of individual professionals. Revenue generation is also peripheral to the primary funding processes organized through the official budget. Revenue generation is the flip-side of petty cash in the sense that petty cash can be used to purchase materials and pay nominal labour rewards for revenue generation projects which operate outside the budget process. These three processes provide occupational therapy with a small-scale alternate economy. But the funding of real occupational sessions and projects is miscellaneous, petty or otherwise separate from the official financing in hospitals and in the provincial and federal government departments which fund mental health services.

By tracing the everyday program activities to institutional processes, we can see that there is an interplay between program philosophy and funding. The interplay between program philosophy and funding structures program space and time. Moreover, the interplay is observable in the location and schedule of actual program activities. It seems that the interplay between program philosophy and funding in transitional mental health programs produces programs which emphasize simulated over real activities. Therefore, neither philosophy nor funding processes act alone. They act in tandem. Furthermore, the variations in programs actually display the combinations and permutations which are possible from this interplay. Program philosophy, in particular, produces variations in program content since decision making around interpreting program philosophies is allocated to the professional team in particular sites. Therefore, in specific programs, professionals who favour simulation can draw heavily on psychoeducation and make little use of the three funding processes which support occupational sessions. At the other end of the spectrum, professionals who favour critical reflection and action can draw heavily on psychosocial rehabilitation (and occupational therapy) and make extensive use of a materials budget, petty cash and revenue generation. However, even where professionals favour real action, real life practices receive only minuscule funding.

As the analysis in each chapter has shown, an institutional ethnography displays the complex coordination and intersection of diverse work processes. This chapter shows how program philosophy and funding processes intersect to organize space and time such that programs emphasize simulation over real life. By briefly linking this analysis with those in Chapters 3 to 5, we can see how the emphasis on simulation in everyday practice is not produced by face-to-face decision making but by connections between multiple institutional processes. For instance, philosophy and funding processes are not the only processes organizing space and time. Philosophy and funding also intersect with assessment, admissions, case management and hierarchical decision making processes. Although these processes seem to have diverse purposes, in combination, they support the emphasis on simulation. Through this interconnected set of institutional processes and practices, occupational therapy is made accountable primarily for organizing the simulated experiences needed to categorize and manage medical cases within medical facilities and professional day-time schedules. Simulation is also emphasized by conceptualizing and categorizing patients/cases rather than real people; by making practice accountable for the quality and efficiency of managing the actions of individual cases rather than the interconnected actions of people in real circumstances; and by controlling people's involvement in collaborative decision rather than including them as partners in structuring the philosophy, funding, space and time frame of programs consistent with their subjective knowledge of their real needs. Although there are some differences in the connections produced when programs are oriented to psychoeducation or psychosocial rehabilitation, the combined effect of these institutional connections is generalizable: there is an interplay in which simulation is emphasized over real life experience.

6.6 Summary

An ideal empowerment-oriented practice engages people in real life education. Occupational therapy's historical and contemporary philosophic grounding in people's real lives and the use of real occupations as a medium for practice suggest considerable potential for developing this core feature. Investigation of the actual practice of seven occupational therapists in transitional mental health programs across the Atlantic provinces indicates that, in renovated houses, more than hospitals, there are glimpses of an ideal practice. To some degree all occupational therapists use real kitchens, work areas and other real space. In some situations, they venture into people's real homes, work places and places of recreation. As well, occupational therapists use a real five-day work week as a program time frame. Within this schedule, there are varying amounts of time spent in real occupations such as cooking, clerical work, maintenance. In some settings, occupational therapists engage people in real, public situations where people make presentations and participate in voting, writing briefs and so on.

The tensions which surround this feature are that occupational therapy's grounding in people's real lives is submerged by institutional requirements to manage medical cases in medical facilities and professional day-time schedules. Occupational therapy practice has been distorted into the artful simulation of life separate from people's real experience and situations.

In psychoeducation programs, occupational therapy is distorted to fit within facilities and schedules which favour interaction and simulation over real action. Real homes, workplaces, recreation facilities and so on are occasionally visited as part of an occupational therapy assessment or during outings. However, the defined program space consists of an efficient juxtaposition of individual and group counselling areas. This use of space enables a number of people to practice reflecting, interacting and role playing life situations, while also undergoing testing and treatment, where they can be observed and coached during day-time professional work

hours. Psychoeducation both organizes and justifies this use of space and time. Psychoeducation is oriented to enabling people to intellectually reflect on simulated versions of life. People are left to transfer simulated learning into real situations. In psychosocial rehabilitation programs, occupational therapy is less distorted than in psychoeducation programs. However, even in psychosocial rehabilitation programs, practice is distorted to favour action in simulated more than real life conditions. In psychosocial rehabilitation programs, the facility is structured to represent real home, employment and leisure facilities. Here people can integrate critical reflection and real action. Occupational therapists in these programs also visit real homes, workplaces, recreation facilities. However, the majority of time is still spent in program conditions which do not represent the diversity of problem situations which people face in their real lives.

Overall, philosophy, funding, space, time and other institutional processes intersect to structure program activities which emphasize simulation over real experience. Although programs are called 'transitional', they generally support people through only the early stages of transition from hospital care to everyday living. Moreover, programs are structured to support simulated learning experiences but not the transfer of learning into people's real situations. The intersection of various institutional processes makes occupational therapy primarily accountable for using simulated program activities as a method of categorizing and managing individual cases within program facilities and the day-time schedules of professionals. This organization narrows and distorts occupational therapy so much that its work with people's real occupations is almost submerged.

CHAPTER 7

RISKING LIABILITY

7.1 Introduction

In addition to the features already analyzed, an ideal empowerment-oriented practice includes *enabling risk taking to produce transformative change*. Literature outside occupational therapy indicates that an ideal practice challenges and guides those with the least power in society to take the risks of transforming themselves and society. An ideal practice enables people to take the risks of changing personal perceptions and actions as well as the institutional processes and practices which are barriers to their empowerment. In this chapter, possibilities for occupational therapy to develop this feature are shown in literature and actual practice. Occupational therapy enables people to reduce some individual and social¹ barriers to their empowerment by organizing graded challenges which guide people through at least some processes of change. However, this feature is doubly constrained. Occupational therapy literature and actual practice are virtually silent on the risk taking associated with change. As well, occupational therapists challenge individuals to change everyday life without challenging them collectively to transform institutional processes which limit empowerment. The analysis displays tensions around this feature by analyzing the work processes of 'risk management'. Occupational therapists may wish to challenge and guide people to develop their potential. But their professional and institutional responsibility is to minimize risk. On the one hand, risk is minimized to protect people's safety. But risk is also minimized to protect professionals and institutions against liability suits for malpractice or negligence.

¹ Although occupational therapy's own discourse refers to 'environmental barriers', the thesis refers to 'social' barriers so that the thesis language is consistent with most literature on empowerment (see Chapter 4, Footnote 1).

7.2 Enabling Risk Taking to Produce Transformative Change: An Ideal Practice

Risk taking is necessary for real personal growth and social change (Freire, 1972; Moscovitch & Drover, 1981; Whitmore & Kerans, 1988; Young, 1990). Furthermore, personal growth and social change are necessary to transform powerlessness into enlightenment, empowerment and emancipation. Yet transformative action faces multiple risks of shifting from "what is" to "what might be" (Fay, 1987; MacIntyre, 1984).

The features described in Chapters 3 to 6 of an ideal empowerment-oriented practice hold a particular emancipatory vision of 'what might be'. The vision is of disempowered people being recognized and educated as 'persons' who are equal partners in making decisions about transforming themselves and the social context of real life. The feature added in this chapter is that an ideal empowerment-oriented practice challenges and guides people through the risk taking required to transform individual and social barriers to their empowerment.

In an ideal empowerment-oriented practice, risk taking is problematic for both people and professionals since responsibility for risk taking is shared. The problem lies in determining whose judgement prevails in decision making, particularly where risks are high or mental judgement is impaired. In particular, it is difficult to decide how much risk is enough. Too much risk taking is overwhelming; too little risk taking results in too little change. Therefore, an ideal practice enables people not only to take risks but to share responsibility for decision making about their readiness for risk taking in contrast to relying solely on the 'expert' decision making of teachers, therapists, or other professionals (see also Chapter 5.2).

In an ideal empowerment-oriented practice, there are three interconnected areas in which to enable risk taking, each requiring judgement of people's readiness. First, individuals are challenged and guided through the psychological and spiritual risks of undergoing a 'perspective transformation' to change their 'meaning perspective' on life. The psychological risks are in

accepting personal responsibility for exercising power, including the guilt and sense of failure as well as the power and sense of accomplishment. This means guiding people through anxiety and fear as they recognize that they are autonomous active agents with an internal locus of control (Mezirow, 1978, 1990). The spiritual risks may involve changing beliefs about personal power and meaning in relation to a larger power (Adamson, 1990). The risk here is in leaving the protective comfort of known beliefs while trusting in the potential liberation of new beliefs. Therefore, in challenging people to risk undergoing a psychological-spiritual transformation, an ideal practice enables people to be decision making partners in judging their readiness to take psychological-spiritual risks. Professionals collaborate with people in determining how they might generate inner control, courage, strength, faith, hope and optimism. They support people through pivotal moments by guiding them to feel empowered.

Second, individuals are challenged and guided through the risk taking required to transform powerlessness in their real everyday actions. For instance, individuals face pivotal moments in which their physical or mental competence is insufficient to overcome barriers which limit their empowerment. Examples of such moments occur when individuals discover that they lack the knowledge and ability to use transportation, find employment, or stop being abused. In an ideal practice, such people are challenged and guided through the personal risks required to transform their competence to act in real everyday situations (Fay, 1987; Smith, 1987). Through decision making partnerships, individuals are guided through just-right-challenges. An ideal empowerment-oriented practice educates people to exercise control and responsible decision making in increasingly complex, chaotic, unpredictable and physically unsafe, real life situations. Therefore, part of an ideal practice is to enable people to risk failure as well as success. An ideal practice uses real incidents and crises to guide people not only to feel empowered but to act empowered.

Third, people are challenged and guided, individually and collectively, through the risks of transforming society. This means that professionals challenge people to risk engaging in critical reflection and real social action (Freire, 1985). For instance, professionals might challenge and guide people to change hierarchical practices which exclude them from decision making about the policies, finances and laws which govern professions and institutions. In essence, the ideal vision (unlikely as it may seem in actual practice) is of professionals challenging and guiding people to transform the ruling apparatus. In an ideal practice, people share the responsibilities and consequences of risk taking with professionals. People and professionals form a partnership in risking political and legal sanctions against actions which threaten to change the power and resources of dominant groups, including professionals (Moscovitch & Drover, 1981; Whitmore & Kerans, 1988). Practice challenges people to risk taking individual and social action to institutionalize their empowerment.

However, an ideal practice not only enables risk taking. Practice also protects people's safety from potentially harmful risk taking. This aspect of an ideal practice requires professionals and institutions to develop conditions which protect people's safety without limiting their empowerment. An ideal practice does not negate professional and institutional responsibility for protecting people's safety. Instead, it makes the work of enabling risk taking accountable as a positive feature of official practice. Accountability is demonstrated by documenting collaborative decision making (see also Chapter 5). With respect to risk taking, an ideal practice develops institutional processes for people and practitioners to document the shared expertise, reasoning and activities (Schon, 1983) behind judgements about risk taking and safety. Consistent with an ideal empowerment-oriented practice, such documentation makes people and practitioners legal partners in sharing the responsibilities and consequences of risk taking (Rinas & Clyne-Jackson, 1989; Rozovsky & Rozovsky, 1990; Rozovsky & Rozovsky, 1992).

7.3 Guiding Development and Adaptation: Occupational Therapy Literature

Occupational therapy literature shows some evidence of enabling risk taking consistent with an ideal empowerment-oriented practice. Although the term 'risk taking' rarely appears in literature, there are many references to enabling 'just-right-challenges' to promote 'development'. The concept of challenging people to change is also present in occupational therapy literature on 'adaptation'. Occupational therapy has even declared its interest in change by describing the profession as a "science of adaptive responses" (King, 1978, p.429). In fact, "adaptation" and a "developmental perspective" have both been included in occupational therapy's generic conceptual framework (Canadian Association of Occupational Therapists, 1991, pp. 53-55). These writings convey a liberal perspective of hope in challenging people to develop their personal potential (Fay, 1987). Moreover, occupational therapy's interests in people's development and adaptation include changing the conditions in which people live (see Chapter 4). Therefore, there seems to be implicit awareness of the risk taking associated with social as well as individual change.

However, much of the literature on occupational therapy's developmental perspective refers to working with children (Banus, 1979; Llorens, 1970). As well, occupational therapy's claim to be a science of adaptive responses tends to limit the profession's vision and practice to techniques and equipment which adapt individual situations (see Chapter 4). In general, discussions about creating graduated challenges offer no critical analysis of the risk taking required for either instrumental or transformative change.

A key limitation in developing this feature of an ideal practice seems to be occupational therapy's mechanistic concept of change. Both the conceptual Model of Occupational Performance (Canadian Association of Occupational Therapists, 1991) and the practice Model of

Human Occupation (Kielhofner, 1985a) depict change from a systems perspective².

A systems perspective draws on organizational theory in which practices are depicted as a process in which various types of "input" undergo various applications during "throughput" before "output" (Etzioni, 1964). Change is measured by describing or calculating differences between "input" and "output". Systems theory is based on assumptions that human behaviour is an object which can be managed within pre-defined boundaries. While human behaviour may change, the structure of the system remains essentially the same. The system is viewed as an object rather than an interdependent relational process (see Chapter 4). Therefore, possibilities for changing behaviour and the structure of society in a system are conceptualized as occurring within the boundaries of the system. Furthermore, the responsibility (and blame) for change is allocated within individuals without acknowledgement of the interconnectedness of individual action and systemic (institutional) processes (Marantz, 1990; Ryan, 1976; Smith, 1987). Although a system may be adapted to people changing as individuals, a systems perspective precludes possibilities for actually transforming individual perceptions or actions beyond that envisioned by the system. Furthermore, no possibilities are included for transforming the institutional practices which govern the system. Essentially, possibilities for empowerment which challenge the system itself are beyond the scope of practice which operates from a systems perspective.

Therefore, tensions around enabling risk taking are, in part, organized by occupational therapy's systems perspective. To illustrate the limitations of this perspective, occupational therapy theory seems to have become stuck in a management view of making order out of

² There are a number of other practice models in occupational therapy. However, the Model of Human Occupation is the most comprehensive in directing practice to attend to individuals as whole persons who engage in a social context.

disorder (Lincoln, 1992³; Rogers, 1982). There seems to be a mechanistic rather than a transformative vision of "change" defined as:

the process of altering or minimizing disorder and achieving new states of organization (Kielhofner, 1992, p.85).

While occupational therapists describe practice as enabling people to change real life, tensions abound since there is no critical analysis of the systems perspective prevalent in current theoretical frameworks. Without critical analysis of this perspective, occupational therapy is unable to articulate its potential and constraints for enabling the risk taking required to produce transformative change.

Furthermore, there is no reference to the difficulty of protecting people's safety while also enabling them to engage in just-right challenges. Occupational therapy refers to structuring conditions to support people's development and adaptation (Canadian Association of Occupational Therapists, 1991; Kielhofner, 1985a; Reed, 1984). However, typical provincial occupational therapy legislation and occupational therapy's national code of ethics (Canadian Association of Occupational Therapists, 1993d) refer to professional conduct, responsibilities and disciplinary action associated with malpractice or negligence. There are no requirements to share legal responsibility for risk taking in these descriptions of practice.

³ Lincoln highlights differing visions of order and disorder in concepts of health as outlined in her "Table 1: Contrasts Between the Medical and Occupational Therapy Models". The table was constructed by Egon Guba in 1987 from discussions with Joan Rogers, a prominent American occupational therapist.

7.4 Enabling Risk Taking to Change Everyday Life: Glimpses of the Ideal Vision in Occupational Therapy Practice

The tensions of guiding people through just-right-challenges are evident in actual practice. Attempts to support people through challenges are constrained in part by occupational therapists' lack of critical awareness of the transformative process of change. However, this feature is also constrained by policy and legislative processes designed to protect people's safety and the liability of professionals and institutions (see Section 7.5 below).

Nevertheless, there are glimpses in which occupational therapists appear to enable the risk taking required for transformative change consistent with an ideal empowerment-oriented practice. Therapists appear to enable social, physical, psychological and possibly spiritual risk taking both within and beyond program facilities. The glimpses presented below show occupational therapists encouraging people to risk attending stigmatized mental health programs; to risk using potentially dangerous materials; and to risk exposing their vulnerability in everyday occupations. Furthermore, a small amount of institutional support for enabling risk taking appears to exist in program brochures.

One glimpse of occupational therapists enabling social and psychological risk taking can be seen as they encourage people to attend the program openly each day. Historically, people diagnosed with mental disorders have been negatively stigmatized (Foucault, 1965; Illich, 1978; Leighton, 1982). Peoples' diagnoses of mental disorders and their admission to mental health services have traditionally labelled them as members of a powerless social group which is dependent on professionals and the state (Cohen & Scull, 1983; Doerner, 1981; Howell & Bayes, 1981). In starting a Friends of Schizophrenia group as an offshoot of the program, Bev describes the difficulty of getting past this stigma:

The biggest concern that people are expressing is the stigma - even just belonging to the group. Another fear they express is that their relatives or friends will know where they are going - and they won't like it. (Interview with Bev, BINTOT01, 1283-1289)

Occupational therapists encourage people to take the social and psychological risks of attending mental health programs despite the lingering stigmatization of being associated with mental health services⁴.

Another glimpse of occupational therapists enabling risk taking is visible as therapists guide people in using the equipment available in program facilities. Where present (in five sites: B, C, J, N and P), workshops have saws and other tools which can produce physical injuries if used haphazardly. There are also pulmonary, cardiac, neurological and other bodily risks in working around sawdust, glue fumes and other chemicals used in various handcrafts and work projects. Kitchens have knives, stoves, poisonous chemicals and other sources of potential physical harm. Maintenance projects bring people into contact with paint, solvents, cleaning fluids, garden chemicals and machinery for mowing lawns and blowing snow. Recreation activities engage people in sports where there are risks of falling, tearing ligaments, being hit by other players' rackets, and so on. In sessions which use equipment, then, occupational therapists enable people to take the physical risk of engaging in the material world.

To those of us who readily engage in the material world, engaging people in such action may hardly seem like enabling risk taking, let alone enabling people to change their powerlessness. However, these are people whom society fears as dangerous: some have actually harmed themselves and others before (and during) attendance in these programs. As well, most people attending programs have previously been removed from the material world by voluntary

⁴ Of course, by encouraging people to attending these programs, occupational therapists may, with some people, perpetuate dependency on professional expertise rather than enable risk taking (see Chapter 5).

(occasionally involuntary) admission to a psychiatric unit. It is rare for people to be admitted to transitional programs without a prior hospital admission for psychiatric treatment. In hospital, people have been powerless to use much more than the basic materials of life: food, beds, and simulated occupations⁵.

Related to enabling people to attend these programs and engage bodily in the material structure of programs is the work of engaging people in program sessions. In this, occupational therapists enable people to take the psychological and social risks of publicly exposing uncertain ideas and abilities which have already earned them a diagnostic label as mentally disordered, lacking mental power to manage their own lives. For some people, then, risk taking to engage in group discussions or meal preparation, even within the simulated conditions of programs (see Chapter 6), is an important, safe step in transforming powerlessness.

Occupational therapists nudge and prompt risk taking by giving a "gentle push".

What I'm doing is giving them some guidelines, or facilitating them to solve their own problem. But it's sort of more with a gentle push, a sort of supportive pushing that we do here. We try to let them know that it isn't judgemental. It doesn't matter if they fail. But you better darn well get out and try it. That's what we don't like. It's not that you fail that we don't like. It's whether you try. We try to make it a really big gentle push! I don't see being supportive, and being there for people, in any way - certainly it fosters dependence in some people - but hopefully we're alert to that in most cases. The real thing that we try to do is provide that support by saying - 'What can you do about it?' 'How are you going to do it?' And, 'I'll be here if that doesn't work. But you give that a try first'....but on the whole, even to get people to the point where they can say 'I'll try it on my own but I don't have to be alone if I fail'. I think that can be empowering. Just knowing there is somebody there can be empowering (Interview with Rita, RINTOT10, 301-375)

⁵ One of occupational therapy's important functions in hospital services is to enable people to retain bodily contact with the material world. This function tends to be overlooked when occupational therapy defines its therapeutic functions in terms of 'developing self esteem' or other psychological interests. Yet, people who have experienced extreme isolation or severe physical disabilities, such as Sue Rodriguez or Nancy B who have been in Canadian news stories in the 1990's, suggest that the experience of being unable to engage in the material world is one of devastating disempowerment.

Rita offers a safety net in which "I'll be there if it doesn't work". With her support, she urges people to develop the internal control, courage, strength, faith, hope and optimism to "try it on my own, but I don't have to be alone if I fail". She also locates risk taking in the practical events of engaging in the material world.

Other glimpses are of occupational therapists enabling people to take the psychological-spiritual risks, physical, cognitive and emotional risks of changing 'what is' to 'what might be' both within and beyond programs. It appears that therapists use programs to enable people to risk releasing and pursuing dreams which, as Pat says, they may never have dared to consider:

Somebody will be able to identify something that has been missing. And they've never had an opportunity to try. Or they've never taken a risk to try. That might sound funny. But that is the case, quite often. And I think, as soon as I start having that conversation, I'm getting a bit of a handle on what they think of themselves, and what they've allowed themselves to do, and what they haven't. (Interview with Pat, PINTOT08, 808-821)

In this situation, Pat is referring to engaging people in handcrafts which people may never have thought of as a source of meaningful satisfaction. She shows awareness that people need to develop a vision or a dream of what might be. Pat seems to be guiding people to take the risk of mapping out a transformative route for changing powerlessness through new types of thought and action⁶. Her emphasis is on people transforming their perception that they lack power. As well, Pat guides people to risk developing their physical and mental (cognitive and emotional) competence as part of changing everyday life. In some instances, Pat, like other therapists, may be challenging people to take the spiritual risks of contemplating new visions of life with new meanings.

In real life situations, people are challenged and guided to risk having the courage and skills to try new experiences. Nora describes her support of 'Peter' in volunteer work as a step

⁶ Pat's emphasis on handcrafts, rather than other occupations, as the practical route for fulfilling meaning and a vision of empowerment is analyzed in Chapter 8.

towards possible employment.

We've been doing a lot of reinforcement for what he does - encouraging John to take risks - to go into new situations. He's really afraid to do anything like that. He has one of the most extreme problems in self-esteem that I think you might see. The surface looks great. So, we've been having a lot of major set-backs recently. They have a lot to do with me suggesting new volunteer placements. The thought of going into a new situation like that - just gets into depression and all kinds of things. Not much leeway for pushing. But at the same time John requires that. So there's a real fine balance to draw there. (Interview with Nora, NINTOT01, 433-451)

Nora's interests in Peter are psychological but her approach to enabling risk taking is 'occupational' so is grounded in everyday life. She links Peter's "problems in self-esteem" with her encouragement to "take risks - to go into new situations". She is supporting him to take the psychological risk of "depression and all kinds of things" if his precarious self esteem is not sufficient. She has located "volunteer placements" as a situation in which she decides that there is a just-right-challenge without the excessive threat of failing at actual employment. In consulting with Peter, Nora encourages him to be a collaborating partner in deciding his own potential for risk taking and the conditions for taking the risks of trying volunteer work.

Jill's reference to an "activity-based way" of helping people also highlights the issue of using "your clinical judgement" and the importance of people experiencing "consequences" such as making a "little fall".

... even if we let them make a bad decision - again, you have to use your clinical judgement, if it's a real rotten decision - you don't let them have a big fall over it. But if it's a little fall, sometimes it's best, obviously to let them make that decision. Because then, I think they realize that, not only do they make the decision, but they have to take the consequences that come with it. And that we don't take that [responsibility] either. And I think the beauty of the whole idea of empowerment in occupational therapy in a facility like this is that we have a chance, in a very concrete, activity-based way, to reinforce it, and practice it all the time. You don't just talk about it. It's even to the point of - they say 'Jill, should I do this or this?' I say 'I don't know....I'll explore it with you'. So I think we have opportunities for experimenting. (Interview with Jill, JINTOT01, 1883-1907)

As Jill says, "you don't just talk about it". She highlights the importance of using everyday

occupations as an educational opportunity for enabling risk taking, even if people's power to act is changed in only small aspects of everyday life. Her response of "I'll explore it with you" also suggests her attention to constructing people as active partners. Yet, she also says that she might "let them make a bad decision", implying that she is ultimately in control⁷.

Furthermore, as Brenda and Rita talk about the program as a "bridge", Brenda displays her trust that Rita will guide her through the challenges and risks associated with her transition out of the hospital system and into a new life in the community.

Br: I really see this as a bridge between the hospital and being out on my own. In the hospital, you're nurtured and protected but in the program, as you say, you have to speak up for yourself.

Rita: We try to make you responsible for your self. We see ourselves as guides helping you to make some changes which you decide are important to you. There's a lot of hard work because no one can do it for you. (Observation of Rita, ROB11, 407-422)

Brenda points to the usefulness of this bridge in enabling risk taking where "you have to speak up for yourself". Then Rita proceeds to indicate that she will support Brenda as a "guide" while she risks doing the "hard work [which] no one can do...for you". It is important to note that guiding people to "speak up" for themselves represents considerable personal transformation if they have not spoken up previously. Therefore, Rita offers a glimpse of enabling Brenda to take risks which may produce transformative change even though the talk is of "transition".

There is also a glimpse that this feature of practice has some philosophic support in official institutional documentation. The programs in this study are all officially designated as part of a provincial set of 'transitional' mental health services. There is an official expectation that the work in these programs is oriented to change. Official brochures even offer an institutional challenge to people to:

⁷ Occupational therapists continually display the contradiction of attempting to be collaborative while using the discourse of a dominant profession.

live a healthy, productive life (Site B)

make changes you wish in your life (Site C)

develop skills (Sites J & N)

learn to cope with life problems in a constructive manner (Site P)

enhance functioning in this community (Site R)⁸

These statements may not seem like much of an institutional challenge to take risks⁹. However, I can only imagine their effect on people who have been categorized as passive patients and hidden behind the closed doors of hospital wards or psychiatric offices. Instead of offering treatment, occupational therapy, as part of these programs, is implicitly challenging people to have the courage and optimism to take risks to "live a healthy productive life", "make changes", "develop skills", "learn to cope", and "enhance functioning in the community". People do not always arrive at programs with a vision of change. However, brochures convey a professional and institutional vision of what might be. They carry a vision and "language of possibility" (Freire, 1985, pp. xvi-xvii). Through these documents, occupational therapists and mental health services in general suggest a future which is different from the past. They offer to support changes which must sound like an almost impossible, but desirable, dream to people who, as these descriptions imply, are unhealthy, lacking skills, unable to cope and dysfunctional.

In these glimpses, it appears that actual practice (despite the systems view described in Section 7.3) is not limited to adjusting individual behaviour within systems. Occupational therapists gradually elicit dreams, use gentle nudges, and guide people to persist towards their visions of transforming life despite barriers and setbacks along the way. These examples provide

⁸ Site M's brochure describes the program rather than what people will do.

⁹ People who attend programs have generally not seen a program brochure before they agree to come. Nevertheless, people generally see these brochures once they start coming to programs since they are posted on bulletin boards and in waiting areas.

glimpses of occupational therapists enabling people to take the risks of actually transforming the ways they think and act in society. In enabling people to risk attending programs and engaging in ordinary life, occupational therapists enable people to transform their view of themselves and their actions as valued members of society. As well, occupational therapists are also encouraging people to challenge and transform society. As people with mental difficulties demonstrate their own courage in challenging stigmatization and fear, they are also daring people throughout society to transform social expectations so that these people can be included (see also Chapter 8 on 'enabling inclusiveness').

As well, there is some collaborative decision making as people decide whether or not to take the risks of attending programs, using program equipment and participating in various parts of the program. Although people are not partners in deciding program conditions (see Chapter 5), they collaborate in deciding on the risks and protection appropriate to everyday situations.

7.5 Managing Safe Risk Taking: Subduing Transformation

Although there are glimpses of occupational therapists enabling people to take the risks required to transform their personal perspectives and actions, this feature exhibits strong tensions in occupational therapy's mental health work. The work of enabling risk taking subdues people's transformative potential. While small transformative change may occur in the ways people think and act in their personal lives, practice more clearly manages people to safely fit into existing conditions within programs and society. Occupational therapists face barriers in their own lack of critical awareness of the limitations of describing, people, society and practice from a systems perspective. However, tensions around this feature are organized in institutional processes and practices. In mental health services, barriers to enabling the risk taking required for transformative change seem to be organized in processes through which the institution of mental

health services manages risk. Risk management confines the work of enabling risk taking by protecting people's safety without sharing the responsibility and consequences for risk taking.

Before displaying risk management, I need to emphasize that occupational therapists, like other team members, are working with some people who have exhibited real danger to themselves or others¹⁰. As Nora indicates:

The issues I've had to deal with him are explosive behaviour at home, not here. Because he's so paranoid. And combined with that, he's got a really bad temper. He's dangerous...hitting someone, he might strike out. (Interview with Nora, NINTOT01, 460-480)

Occupational therapists are working with people who may be unexpectedly "explosive" or who may exhibit "bad temper" in which they "hit someone" or "strike out". Given that 97% of occupational therapists are women (Canadian Association of Occupational Therapists, 1993b), enabling such people to take risks appears to be a form of professional risk taking in itself. In mental health programs of any kind, the consequences are high as I noted in listening to Jill.

[Jill] commented on the magnitude of problems that occupational therapists are dealing with - that people are potentially suicidal or violent in numerous cases - that the style of interaction and way of working very much influences whether a situation will run smoothly or will blow up ...that the therapist is continually gathering information from observing people doing things, interviews, formal testing, meetings and phone discussions with other professional workers, discussions in various contexts with family members, etc. -on the basis of that information, the therapist processes the impressions and interpretation of the developmental issues facing that person - the therapist links those impressions with a judgement on the most appropriate activity to increase performance in work, self care, and leisure. (Observation of Jill, JOB02, 790-831)

Jill points to the potential that people are suicidal or violent. She indicates the complexity of "continually gathering information from observing people doing things...." as an underpinning to the decisions made about "developmental issues facing" a person. Enabling such people to take risks, then, carries danger: too much risk will provoke severe consequences such as suicide

¹⁰ The problems of danger are connected to people's mental difficulties (described in Chapter 3.4 and Chapter 5.4) and to social responses to these difficulties (Bachrach, 1977).

or violence.

Bev's comments point to a related concern: that people have had frightening experiences and are afraid to risk "losing control". As Bev says, one woman:

...found group therapy going too fast and decided to stop attending...she described fears about re-living past physical and sexual abuse...she would rather repress feelings of anger and guilt than risk losing control should she discuss the past in a group...she agreed to meet individually. (Observation of Bev, BOB03, 248-256)

Some people limit their own risk taking. Some people are so afraid to acknowledge their powerlessness that they create their own barriers to transformative change.

Nevertheless, constraints for occupational therapists enabling these people to judge and take at least some risks also lie in institutional policies and practices. For example, the sense of threat and need to control risk is visible in policies such as "Bomb Threat". In Site P, a policy and procedure for responding to telephone and mail threats is outlined, and a "check list" is provided to guide a staff person through "Questions to be asked", "Description of voice" and "Background noise". The clear message is that the staff member is to prolong the threat long enough to gather information for police. Programs are both the target of threat and accomplices of police in controlling social violence. Policies which remind staff that they are potential targets of violence do not engender a spirit of adventure in challenging people to risk changing the organization of power in society. In other words, the potential for real danger means that risk needs to be controlled to some degree.

Less dramatic than bomb threat policies are the official documentary practices of 'risk management'. Risk Management is officially concerned with protecting people's safety rather than with enabling people to share responsibility for risk taking. Official management of risk requires occupational therapists and other professionals to create textual evidence of specific

'incidents' and 'crises'¹¹. The evidence of incidents or crises involving 'patients' is documented in an individual's health record. As an example, the incident report in Site R requires documentation under the categories listed in Table 13.

Table 13	
Categories of Risk Management Documentation: Site R*	
Type of incident (including 'fall', 'hazardous materials', 'disturbance')	
Person involved (patient, visitor, etc.)	
	<ul style="list-style-type: none"> - patient status (activity level and condition) - type of injury (burn, strain) - medication incident (incorrect drug, allergy, etc.) - notification, as applicable (including options for in-charge person, next of kin, emergency, public relations) - description of incident and action, follow up, treatment, comments, physician comments
* Reproduced from actual document without location identifiers.	

The incident report is completed by the staff person involved. There are strict guidelines about what is included and when to actually report an "incident". Rita describes how some incidents do not actually qualify for documentation:

When I had two incidents in the space of a Monday to Friday, I was told they absolutely do not go on the chart....in one situation, a patient took an overdose in the washroom. And one patient had a seizure - so they weren't cutting their fingers on our scissors or something like that. (Interview with Rita, RINTOT07, 640-658)

Risk management policies and procedures, such as in Site R, attend to institutional concerns for physical "injury", such as a burn or strain, or a "medication incident" (Rinas & Clyne-Jackson, 1989; Rozovsky & Rozovsky, 1990; Rozovsky & Rozovsky, 1992). However, risk management constrains more than physical risk taking. Physical or medication incidents may result from

¹¹ References to risk management here are focused on 'patient' safety. However, the full policy, like most risk management policies, covers risk management for staff, volunteers and any others who might be connected with the institution.

psychological or social risk taking in which people take action in response to feelings of powerlessness, threat, anger, loss of hope and so on. Therefore, risk management curtails occupational therapists' commitment to enable just-right-challenges. Given requirements to document incidents, occupational therapists are unlikely to enable risk taking which may provoke incident-type behaviour and eventually result in a threat to someone's physical safety.

Furthermore, the management of risk protects professional and institutional liability. The documentary evidence of incidents and crises is defined as a professional responsibility. Professionals, like Rita, are officially delegated responsibility for risk management on behalf of the institution. Occupational therapy position descriptions state that therapists have:

- responsibility for safety of all patients under therapists' care during assessment and treatment
- interaction with potentially physically aggressive patients

(extracted from Table 1, Chapter 3, Position Description, Site R)

Occupational therapists are officially cautioned that their work involves "interaction with potentially physically aggressive patients". Furthermore, they are responsible for the "safety of all patients".

In talking about taking a group out mackerel fishing, Bev displays this responsibility in ensuring that people have signed their legal consent to engage in a potentially risky activity.

We get them to sign all kinds of consent forms and then we just go and hope no one falls overboard. (Observation of Bev, BOB01, 748-753)

It appears, then, risk management policies and procedures make explicit the documentary requirements for protecting people from harm and professionals' responsibility for protecting people from harm.

Yet, reflection on analyses from Chapters 3 to 6 suggests that there are interconnections through which the institution controls risk taking to a far greater extent than is apparent by looking only at policies and procedures described as risk management. A concerted set of

practices organizes the institution's broad ranging, hierarchical control of risk.

To explain, Chapter 3 shows that people are active in everyday situations. But they are institutionally conceptualized and categorized as passive objects. People are categorized as passive diagnostic cases rather than as active risk takers whose courage and competence might involve them in transforming society. The institutional message is that professionals are responsible for protecting passive patients or cases through a safe course towards mental health.

Moreover, case management appears to be a separate process from risk management (see Chapter 4). However, the individualization of case management forms part of the institutional management of risk by reducing the possibility of groups engaging in social action. As well, being accountable for efficient case management discourages occupational therapists from challenging and guiding people through potentially inefficient processes of transformative change.

Risk taking seems to be particularly controlled by the hierarchical decision making structure of mental health services (see Chapter 5). Occupational therapists, not people, are responsible for managing risk taking. In addition, people attending these programs are not partners in documenting incidents or crises. In fact, people are legally prohibited from having any access to their health records since they are the legal property of health institutions (Rozovsky & Rozovsky, 1990).

There also appear to be connections between risk management and the institutional organization of space and time (see Chapter 6). Occupational therapists enable risk taking primarily in simulated conditions during the early steps of people's transition from psychiatric treatment to everyday life. The facility structures protected opportunities where 'safe' risk taking is guided in empathetic, supportive conditions. However, there are very few community mental health occupational therapy services in the Atlantic or other provinces to challenge and guide people through the risk taking required to transform real life (Townsend, 1988).

At this point, we can see how the work of enabling risk taking is institutionally controlled through an interconnected set of processes. Occupational therapists are officially responsible for protecting people from harm, but they are not officially responsible for enabling risk taking. Moreover, occupational therapists are not partners with people in documenting either risks or challenges since people have no legal access to the health records in which documentation occurs. Although program brochures indicate that occupational therapists challenge people to "live a productive life", "develop skills" or "enhance functioning in the community" (see Section 7.4), the challenges are restricted to those which do not provoke incidents or crises. Should incidents and crises occur, occupational therapists are personally responsible for documenting these events and, as stated in position descriptions, for the failure to protect people's safety.

While there are multiple intersecting processes which manage risk, the documentary process of risk management organizes occupational therapists to produce the official account of incidents and crises in which they were unable to sufficiently protect people from harm. In producing these accounts, occupational therapists are actually producing the evidence which may be required for their own legal defense if people claim that they were victims of malpractice or negligence. Therefore, some occupational therapists may enable people to risk transforming themselves in small ways in the privacy of programs and personal life. However, this seems like an underground practice which can be conducted only to the extent that harm does not occur. If occupational therapists enable the risk taking required to produce transformative change in people and society, occupational therapists are actually risking their own liability.

Furthermore, documentary practices of risk management reproduce hierarchical control rather than collaborative partnerships for enabling risk taking because they organize professionals and people as legal adversaries. This hierarchical, adversarial relation appears to be strengthened through the intersection between institutional practices of risk management and professional

legislation and codes of ethics. For example, like other professional legislation, occupational therapy's legislation and code of ethics are concerned with professional standards, responsibility, liability and disciplinary procedures for professional malpractice or negligence (Canadian Association of Occupational Therapists, 1993d). There are no equivalent references to occupational therapy having an ethical responsibility for enabling people to take the risks required to become empowered or even, in the profession's own language, to achieve their occupational potential (see 'OCCUPATIONAL' DEFINITIONS, pp. xii- xiv).

Ultimately, tensions between enabling risk taking and protecting safety are organized by the objectified decision making used to determine liability in the modern practice of law. Legal decisions are not rendered by participants or witnesses of real events. They are rendered by judges whose decision is based on documentary accounts. Therefore, the individual health records, which are produced by occupational therapists and other health professionals, provide professionals and institutions with the documentation required to engage in the adversarial system of law prevalent throughout much of the world. Of significance, liability claims which reach a court of law have financial implications. For professionals, the threat of liability claims has spawned a huge business in malpractice insurance. As an example, the Canadian Association of Occupational Therapists sells Malpractice Insurance through a national plan. Although employers, such as hospitals, provide general liability insurance coverage to therapists, an individual occupational therapist can still be charged if institutional processes for managing risk have not been followed¹².

¹² Concerns for legal claims are so great that health professional malpractice insurance fees are increasing quickly. Physicians have experienced the greatest insurance premium increases of all health professionals. However, the cost of increased insurance premiums is, of course, reflected in increased fees for medical and other health professional services. The climate of concern about legal challenges is so great that I carry malpractice insurance in case any academic, fieldwork or public statement is viewed as a professional opinion which causes harm.

Overall, risk management is visible in position statements which identify professional responsibility for protecting people's safety and in policies and procedures for documenting incidents and crises. Nevertheless, it appears that the various processes which organize diagnosis, accountability, decision making and the structure of space and time all intersect to manage risk. Certainly, the protection of people's safety is important. However, the concerted power of intersecting processes and documentary practices orients the whole institutional enterprise to managing risk. It seems logical to assume that the overall effect of these processes is to make occupational therapists cautious so that they subdue rather than encourage transformative change. To do otherwise, occupational therapists risk their professional liability and the liability of their employer, mental health services. Therefore, occupational therapy is organized to manage risk far more than to enable risk taking for transformative change.

7.6 Summary

An ideal empowerment-oriented educational practice challenges and guides people to take the risks required to produce transformative change in themselves and society. Occupational therapy literature appears to be somewhat consistent with the ideal in describing the profession's interest and practice around challenge and human development. As well, there are glimpses of an ideal practice where practice enables people to take the risks of changing social conditions as their own perspectives and actions. Although much of occupational therapy literature addresses performance rather than empowerment, occupational therapists challenge people to overcome barriers by transforming themselves and society. Glimpses of enabling risk taking and transformative change are visible in actual practice as people are challenged to take the social risks of attending mental health programs even though this may stigmatize them in the eyes of their family and community. As well, people are guided through the physical risk taking of using

dangerous household, maintenance and trades equipment even though they may have previously threatened to harm themselves and others. In program sessions, social, psychological and spiritual risk taking are facilitated as people expose their personal vulnerability, face the fear of acknowledging powerlessness, and dare to role play real actions in which they remember feeling powerless. Outside program facilities, occupational therapists sometimes challenge and guide people through the risks of engaging in social as well as individual action in the risk-laden conditions of real life. There is some informal partnership between occupational therapists and people when they mutually decide how much risk people are ready to face and how to protect people as they face risks.

However, tensions subdue the transformative potential in occupational therapy's mental health work. Despite an interest and practice around challenge and human development, occupational therapy theory describes people and society (their 'environment') as a system. Change is conceptualized within the system without reference to transformative possibilities which might challenge the system itself. Too, the focus for practice is on enabling individual far more than social (systems) change. In part, the problem of tensions around this feature lies in occupational therapy's lack of a theoretical analysis of transformative possibilities. However, it seems that the main tensions around the work of enabling risk taking are socially organized by the institutional processes of risk management. Policies and procedures document occupational therapists' responsibility for protecting people's safety and define requirements for documenting incidents and crises in individuals' health records. As well, the documentary practice of risk management intersects with other institutional processes and practices. In the protected structure of program facilities and day time schedules, occupational therapists are not official partners with people in sharing risk taking. Instead, practice is organized to enable people to engage in protected transitional experiences within medically-controlled conditions (see Sections 5 of

Chapters 3, 4, 5 and 6). While protection may be appropriate while people are in acute mental distress, protection in transitional mental health programs stifles risk taking. Risk taking is managed so carefully that it is difficult for people to develop the courage, competence and social action required to transform themselves and their real life circumstances.

Beyond the control of risk in everyday practice, the documentary processes of risk management produce evidence to protect professional and institutional liability against legal claims of malpractice or negligence. Therefore, rather than fostering a partnership which supports risk taking, risk management organizes a legal, adversarial (hierarchical) relation between professionals and the people who use professional services. Since both professional and financial consequences for losing legal claims are high, occupational therapy minimizes risk taking to avoid potential liability. While occupational therapists enable some risk taking, they must curtail their work and subdue possibilities for producing transformative change so that they are not risking their own liability.

CHAPTER 8

PROMOTING MARGINAL INCLUSIVENESS

8.1 Introduction

This is the last of the six analytic chapters. It analyzes tensions surrounding occupational therapy's historic attention to 'spirituality' which I link to the social concept of 'inclusiveness'. A spirituality of *global inclusiveness* is described from literature outside occupational therapy as the ethical underpinning of an ideal empowerment-oriented practice. An ideal practice enables those who have been excluded to be included as valued citizens in the public as well as private realms of society. This feature connects an ideal empowerment-oriented practice to social justice. Occupational therapy literature and practice display both possibilities and constraints in working from an ethical foundation of inclusiveness. Occupational therapy literature displays glimpses of possibility in its historical interest in spirituality and social integration even though there is lack of clarity in defining these concepts. Yet, occupational therapists promote inclusiveness mainly within programs. Or they promote the inclusion of people diagnosed with mental disorders in housing, employment and recreation services organized especially for people diagnosed with mental disorders. To display tensions around this feature in actual practice, I analyze occupational therapists' involvement in 'chores', 'discharge', 'follow-up', 'sheltered employment', 'social recreation' and 'special benefits'. What becomes visible is that there is very little potential for enabling inclusiveness unless there is a public ethical commitment to inclusiveness underpinning the organization of professional practice, mental health services management, and the economic and welfare practices of society.

8.2 Enabling Inclusiveness: An Ideal Vision of Society

An ideal empowerment-oriented practice has a spiritual foundation. The foundation is an ethical set of beliefs about the worth and power of people within the world.

By 'spirituality', I mean broad reaching ethical ideas which guide everyday life in the world. Spirituality refers to ideas which extend beyond individual, human thought and reason. It is not limited to organized religion although religion is one form of spiritual expression. I do not assume that organized religions promote inclusiveness. In my observation, most organized religions have great difficulty even speaking inclusively let alone actually practising inclusiveness.

In this sixth feature, I refer, specifically, to an ethical commitment to enable global inclusiveness. This means that an ideal empowerment-oriented practice enables those people who have been excluded historically (by being marginalized, segregated, sequestered, alienated, isolated and so on) to become included as valued members in societies across the globe. As a foundational feature, this ethical commitment is not additive. Rather, it underlies all other features of an ideal empowerment-oriented practice.

For instance, with an ethical commitment to global inclusiveness, recognition of people's power to act in the world takes on a commitment to promote their inclusion as worthy, powerful actors in all realms of society. Beyond conceptualizing and categorizing people as active (see Chapter 3), an ideal practice demonstrates compassion, love, unconditional acceptance, respect, dignity, caring, joy, enjoyment, well-being, empathy, faith, peace and other "healing resources" which recognize people's worth and power (Katz, 1984). Diverse people are recognized as having innate meaning and power in their lives (Bateson, 1989). People's contributions are valued as equally worthy and powerful regardless of social pressures to value some contributions (such as technical prowess) more than others (such as neighbourliness). Professionals who work from a spirituality of global inclusiveness hold themselves as well as others accountable for

practicing with an ethic in which self worth is valued. However, this is not narcissistic aggrandizement of the self (Lasch, 1977, 1984; Giddens, 1991). Instead, it is a commitment to 'do unto others as you would have them do unto you' (Adamson, 1990). Practice based on this ethic openly speaks and acts against oppressive expressions of ridicule, disrespect, lack of empathy, stigmatization, disdain, mockery, callousness, self-righteousness, revenge, violence or other expressions which undermine recognition of people's positive worth and power to act.

Second, an ideal practice recognizes people's interdependence (see Chapter 4). This involves recognizing the embeddedness of individual action in society as a basis for enabling social as well as individual change. A commitment to global inclusiveness compels an ideal practice to become accountable for fostering connectedness as well as personal growth. In other words, an empowerment-oriented practice is accountable for promoting the inclusion of people as members of social groups, communities, clans, nations and other communal groupings across the globe. Therefore, an ideal practice balances support for individual development with support for the development of self help groups, community networks, mutual aid practices, and supportive institutional practices (Biegel & Naparstek, 1982; DeJong, 1979; Kropotkin, 1989; Smith, 1990b). In this ideal, professionals engage in social action which organizes social institutions to include groups as well as individuals which have been excluded. Practice guides people and institutions to celebrate the joy of community as a necessary underpinning to individual accomplishment. Ideas of individual liberty are promoted along with ideas about social responsibility to the communities in which people live (de la Boetie, 1975; Ignatieff, 1984). There is recognition that global inclusiveness does not mean selecting which individuals and groups will be included. Inclusiveness remains unrealized as long as some individuals or groups are excluded. Furthermore, inclusiveness is realized only when it is a public practice in the institutions of society as well as a private individual mode of interaction.

Third, the ethic of inclusiveness strengthens the commitment to collaborative decision making partnerships (see Chapter 5). A commitment to inclusiveness provides the underpinning ethic of equality in partnerships characterized by horizontal collaboration. Hierarchical decision making, by definition, excludes certain individuals and groups from various decision making levels in a hierarchy. Working from a vision of an ideal practice, professionals are ethically committed to people being equal partners with professionals and others in all decision making. In this ideal, then, collaborative decision making about private personal life is extended to decisions about public social and institutional matters. An ideal practice incorporating inclusiveness, in essence, turns hierarchy on its side in order to include people in all aspects of decision making.

The fourth feature is that an ideal educational practice is grounded in real life (see Chapter 6). Here, a commitment to inclusiveness provides an ethical foundation for celebrating diversity over uniformity in real life (Young, 1990). Therefore, an ideal educational practice has sufficient flexibility and diversity to include all learners in real learning experiences and conditions despite their differences (Kittrie, 1971). Flexibility and diversity in an educational practice are developed by structuring space and time relevant to the diversity of learners' real lives. Inclusiveness is promoted by organizing philosophic and financial support for educating diverse people to be valued contributors in real life.

The fifth feature orients an ideal practice to enable the risk taking required for transformative change (see Chapter 7). An ethical commitment to global inclusiveness obligates practitioners to enable the personal and social transformation required for historically powerless groups to become empowered. The obligation is to enable the empowerment of these groups in the name of social justice. An ethic of global inclusiveness guides an ideal empowerment-oriented practice towards a distributive form of social justice in which power as well as resources

are shared (Young, 1990). Therefore, ideas of philanthropy which underpin state welfare as well as community volunteer services are challenged. Practitioners denounce the hierarchical, unequal power relations which characterize charity (Whitmore & Kerans, 1988). An ideal practice also provides a model for publicly declaring a commitment to a spirituality of global inclusiveness in which no social groups are economically or politically marginalized. Practitioners declare this ethical commitment as a foundation for developing a just society which includes diverse people as empowered citizens who hold "entitlement" to an equal share in a community's power and resources (Smith, 1990b, p. 100).

8.3 Linking Spirituality to Inclusiveness: Occupational Therapy Literature

Occupational therapy literature has, until recently, said little about inclusiveness. However, an ideal vision of society shows through as the underlying ethic of this profession. In part, literature has historically referred to meaning and purpose in describing the 'spirit' and 'spirituality' of people's lives. The original triangular badge on occupational therapy uniforms depicted an integrated mind-body-spirit as the domain of occupational therapy (see Chapter 1.5). The badge displayed occupational therapy's historical commitment to attend to people's sense of meaning and purpose beyond their mental and physical well-being. As well, "spirituality" has been incorporated in Canada's Model of Occupational Performance as one of the four components of individuals (the other three are the physical, social and mental components) (Canadian Association of Occupational Therapists, 1991, p. 17). Although not clearly defined, spirituality is the component through which occupational therapists attend to "worth of the individual" and to individuals' meaning, worth, values, and beliefs (p.16).

Furthermore, occupational therapy has a long standing commitment to developing real social networks through lobbying and advocacy which appear consistent with promoting local if

not global inclusiveness (Benzing & Strickland, 1983; Frank, 1992; Tate, 1974) (see also Chapters 4 and 6). In particular, occupational therapy supports inclusiveness described as the 'social integration' of people whose lives are characterized by disability, aging or social disadvantage (Canadian Association of Occupational Therapists, 1991). Without being explicit, occupational therapy has long implied a commitment to inclusiveness by supporting the deinstitutionalization and segregation of people who have been excluded from society (Community Occupational Therapy Associates, 1982; Krupa, Singer & Goering, 1988; Woodside, 1991).

In the 1990's, there are signs that a more critical understanding of spirituality is emerging using the language of connectedness and inclusiveness (Dyck, 1992; Evans & Salim, 1992; Krefting, 1992). In addition, Polatajko describes occupational therapy as "enabling living" so that people with disabilities are included in all aspects of community life (Polatajko, 1992, p.198). Some references have explicitly identified concerns around inclusiveness in different cultural contexts. For example, Kenebanian and Stomph reiterate views that some cultural groups may take care of people with disabilities rather than encourage their inclusive participation within the community (Kinebanian & Stomph, 1992).

The most direct references to inclusiveness have been in culture and gender analyses of occupational therapy. Brown and Gillespie cite Mattingly's work on narrative reasoning in occupational therapy practice. They talk about occupational therapists helping people in "reconnecting and re-engaging with others in a new set of circumstances" (Brown & Gillespie, 1992, p.1003). As well, occupational therapy's philosophy has been described as a "paradigm of inclusion" similar to the feminist, "inclusive perspective...of personal empowerment and social justice for all" (Hamlin, Loukas, Froehlich & MacRae, 1992, pp. 967-8).

Nevertheless, there are tensions around occupational therapy's spirituality of inclusiveness. In particular, individualism is so prevalent that definitions of occupational therapy

generally emphasize personal fulfilment of meaning without reference to people's inclusion as worthy members whose lives contribute meaning to and draw meaning from society. As an example, Grady's vision of occupational therapy states that:

meaningful occupation provides direction for individuals and that successful engagement in the activity leads to individual satisfaction and promotes health and well-being (Grady, 1992, p. 1062).

A multitude of statements such as this individualize, and thus confine, the scope of occupational therapy's commitment to a spirituality of inclusiveness. There is a lack of critical awareness that people's perceptions of "meaning" and "successful engagement" are embedded in the processes and practices of social groups, communities, clans, nations and other communal groupings across the globe. Grady's definition suggests that the aim of occupational therapy is limited to the private realm of personal, "individual satisfaction", "health" and "well-being". Throughout occupational therapy literature, there is silence about ways in which engagement in occupation shapes social as well as individual worth, meaning and power. 'Meaningful occupation' appears to be conceptually confined to the personal meaning defined by individuals.

Tensions also arise where the concept of spirituality is defined narrowly. Many occupational therapists informally describe spirituality with broad references to people's meaning, worth and control in society. Many take pride in the profession for articulating this feature. However, others link spirituality only with religion and advocate for its removal from occupational therapy's conceptual framework (Blain, Townsend, Krefting & Burwash, 1992). They indicate that spirituality is an important part of human life but that it falls outside occupational therapy's domain of practice. Yet, when occupational therapy's spirituality is described as global inclusiveness (Townsend, 1993), occupational therapists have responded positively, saying that this is what they have believed about occupational therapy all along.

8.4 Emphasizing Worth and Community Connectedness: Glimpses of the Ideal in Occupational Therapy Practice

I remember Brenda's first day. She came to the desk with the blankest face I've seen in a long time. Although she's no ball of fire yet, I see her reacting and interacting with other people. Her face has some expression. I think this lady is slowly coming alive. We lose sight of the differences in people when they are not obvious or major. But for her, after all these years of being essentially dead, I think she's slowly coming alive. And, for her, I suspect she's made huge steps. (Observation of Rita, ROB29, 746-759).

This portrait of a lost soul is fairly typical of the people who arrive at transitional mental health programs. Brenda arrived with the "blankest face I've seen in a long time". Over the weeks, she can be seen "slowly coming alive". Like many people with long standing mental difficulties, Brenda has become disconnected, partly within herself and partly from society. People like Brenda live marginalized lives, uncertain of themselves and stigmatized by others who question their entitlement to share the power and resources of society.

Therefore, it is noteworthy that Brenda is connecting with people as a member who is "reacting and interacting with other people" in the program. As I reflected on this statement and on occupational therapy practice in general, I was struck by the practical evidence of occupational therapy's philosophic commitment to 'spirituality'. To a casual observer, occupational therapy may appear to be a mechanistic practice without an ethical underpinning. As well, practice appears to be based in practical rather than ethical concerns: guiding people to define behavioural goals, encouraging people to talk and work together, facilitating role plays of ordinary life situations. Yet, through this mundane work, occupational therapists emphasize the worth and power of stigmatized people, their connectedness with others, and their entitlement to be respected, fully participating members in all realms of community life.

Over and over, in day-to-day interactions, occupational therapists tell people that what they are doing is 'important' and will 'make a difference'. Occupational therapists emphasize

the importance of people accomplishing the most ordinary daily tasks such as making a meal or answering a telephone. People are encouraged to help each other and to verbally acknowledge how each person is connected by the way they contribute as members who are welcome in the group. As Nora says, occupational therapists organize these activities so that people make "natural and real connections" through engagement in real occupations:

The more they kind of work side-by-side with [each other], the more they make natural and real connections, the better they are. (Interview with Nora, NINTOT02, 289-291)

In fostering "natural and real connections", occupational therapists seem to be recognizing the worth of individual persons and highlighting the meaning of their contributions to a collective project. Occupational therapists' conversations are peppered with comments like: 'am I ever glad to see you', 'you have lots of good ideas', 'I respect your judgement', 'we need everyone to be part of the decision', 'we really enjoy having you in the program', 'you deserve a lot of credit for helping [yourself, others]', 'we will support what you believe is important to do', 'I have never been in your situation but it sounds extremely difficult and yet you have managed to keep going' and so on.

To some extent, occupational therapists are fulfilling the institutional mandate to be supportive. As the program description in Site P states:

The programme approach is one of people helping people. Emphasis is placed on developing a supportive group setting which provides a sense of community while simultaneously giving individuals the flexibility to cope with their specific problems.

(Extracted from the Introduction, Programme Objectives, Programme Description (1988), Site P)

Occupational therapists are directed to develop a "supportive group setting which provides a sense of community". Therefore, one might question the genuineness of feeling behind their supportive expressions. Certainly, such comments can easily become as rote and impersonal as 'have a nice

day' can be from check-out clerks in stores. However, my observation is that occupational therapists are generally conveying beliefs that go beyond an institutional directive. Through their tone of voice, posture, attentiveness, soft touching, personalization of statements, and follow up conversation, occupational therapists generally seem to be conveying genuineness. Their statements and attentiveness to people all indicate that they believe that people are worthy, deserve respect, have meaning, are connected as members of the group, and have innate rights to be included as valued partners in decision making.

Within programs, the sense of connectedness is fostered by the confidential information shared by group members. It is quite usual for people to acknowledge fears and failures and to risk trying new things in which they have no ready competence (see Chapter 7). People expose their vulnerability to group members. They do so in a place which treats such exposition as a positive step in healing.

I suspect that group planning for outings or other program events is an important process which enhances inclusiveness within the program (see the discussion of planning groups in Chapter 6.4). Through the practical work of planning these ordinary activities, occupational therapists actively solicit people's involvement, give people's actions meaning within the context of the group, celebrate the diversity of contributions from different people, connect people to one another, create an environment in which people have unquestioned membership rights, and create a forum in which everyone's ideas are included. Outings are also a practical method of social integration where people go as ordinary citizens to businesses, places of interest, recreational facilities and so on.

In general, then, occupational therapists' day-to-day work appears to be infused with an ethical spirituality of inclusiveness and, ultimately, social justice. In this study, inclusiveness seemed most visible in processes called 'chores', 'discharge' and 'follow up'.

First, occupational therapists appear to promote inclusiveness within the program through practical 'chores'. Every program includes chores, usually overseen by the occupational therapist. Chores involve tidying the program space at the end of each day, keeping coffee made for program participants, posting pamphlets on employment or housing options, shopping for meal preparation, gathering information for outings, or watering plants.

One of the key features is that chores set out responsibilities for the types of action related to living as members of a home or place of employment. Of course, some people detest doing chores. Some comment that it feels artificial and demeaning. They say that they do not care if the plants in the facility live since they will only be there for a few weeks and they do not even like plants. These are valid objections. As well, chores can be questioned as being an institutional method for reducing the costs of any extra housekeeping services required by these programs.

But chores represent responsibilities which acknowledge the interconnectedness of people in making diverse but equally meaningful contributions towards a common goal. Some people positively glow when asked to do the shopping for the group's noon meal. Others report with great pride at the daily check-in meeting that they have created a better system for keeping bathrooms clean, keeping track of community events, or getting people to bring their own coffee cups back to the kitchen after break. Site N has particularly developed chores into part of the program with rotating unit supervisors and project titles such as 'Video Technician' and 'Community Events Reporter' which confer public meaning on day-to-day tasks.

Other glimpses of occupational therapy enabling inclusiveness appear in the work of 'linking' and 'advocacy' which are connected with the processes of 'discharge'¹ and 'follow up'.

¹ Linking is described here as part of the everyday process of discharge. The institutional organization of discharge is analyzed in Section 8.5.1

Discharge refers to a management process (also described as 'separation') through which services are officially terminated. Discharge creates a plan so that people know what to do and where to go after they leave programs. Follow up refers to a related management process of checking what people are doing after their official discharge. Follow up is an attempt to ensure that community or other support is enabling people to be included within their communities. In the programs studied, follow up encompasses a variety of actions from telephoning people to seeing people periodically when they return for re-assessment of lingering mental difficulties.

Linking and advocacy may appear to be ordinary common sense types of work. Nevertheless, this work offers practical instances of occupational therapists promoting inclusiveness and social justice. Working either inside or outside program facilities, all occupational therapists in the study 'link' and 'advocate' with and for people to assist in their social integration.

The glimpses of linking for 'discharge' are diverse since this work consists of three fairly distinct processes. First, glimpses of enabling inclusiveness appear in observing that occupational therapists collect community information. They keep files of resource information on recreation programs, employment possibilities, housing options, support groups and professional services. However, occupational therapists do more than keep track of names and addresses. Therapists implicitly or explicitly analyze, select and consider possibilities for adapting the occupations associated with each situation (Cynkin & Robinson, 1990)². Rita points to this component of

² Occupational analysis and synthesis, in its formal implementation, is a central process in occupational therapy. It differs from assessing an individual's occupations. This analysis investigates the inherent properties and character of an occupation: its demands on those who engage in it, and the environmental conditions which enhance or constrain engagement. Occupational analysis involves analyzing the requirements and attributes of any occupation whether simple or complex, segmented or integrated. Analysis may look at an occupational segment such as chopping onions or an integrated occupation such as preparing a meal or even running a household and family. Analysis attends to the physical, sensory, cognitive, emotional and sociocultural requirements for completing an occupation. It also examines the physical,

linking in describing how she gathers information on community resources:

If it's something that I want to go down and see how it's set up, I'll see if they can handle it either physically or emotionally. And, in some real specific way, I'll watch the task being done and see if I think they can handle it or whatever that might be. (Interview with Rita, RINTOT03, 631-639)

Second, linking underpins ongoing assessment which determines when discharge is appropriate. As an example, Carol describes how, after using a "leisure interest" questionnaire in assessment, she:

...might suggest that...the client or patient join some kind of group activity in the community. I may help them prepare their resume, and role play a job interview. Perhaps we talk about banking, grocery shopping. These things that occupational therapists do really fit nicely into supporting the person in their transitional stage back to a more independent life style. Often I work with young people who are looking at making the transition from being quite dependent on parents or family, to getting their own apartment, or moving into a community residence. I might help them with things like meal planning, budgeting, things like that. (Interview with Carol, CINTOT02, 84-103)

The ongoing assessment is about "banking, grocery shopping...supporting the person in their transitional stage back to a more independent life style". Carol is beyond gathering the initial, intake, screening, preliminary or other assessment information needed to justify initial program

social, cultural and other environmental features (lighting, tools, presence of other people, time, costs, policies, legal parameters, etc) which shape an occupation. Of note in analyzing a spirituality of inclusiveness, the analysis identifies the spiritual dimension required for engaging in an occupation (meaning, purpose, motivation, values, assumptions, attitudes).

If the analysis reveals that an occupation requires particular knowledge, cultural attitudes and decision making skills, then performance of that occupation provides a medium in which to learn to integrate such knowledge, attitudes and skills. On the one hand, occupational analysis dissects an occupation. On the other hand, this type of analysis develops hypotheses about the developmental potential and/or the societal implications contained in the material, interactional, organizational and other dimensions of the occupation. Occupational therapists match or 'link' assessments of individuals with analyses of occupations. The observable part of this linking is that occupational therapists recommend that people become involved in a particular occupation. Occupational therapists' informal or formal analyses of occupations underlie suggestions that people join a particular recreational program, apply for a job, meet with someone to see about a housing option, or sign up for a night class. The end result - handing someone a telephone number and a map of the bus route, or guiding them to locate information in a resource binder - appears simple, technical and ordinary.

admission (see Chapter 3.4). Her assessment in this circumstance is part of the process of linking people to activities which included them in society. An ongoing assessment provides information for deciding whether people need to stay in or be discharged from programs. The questions underlying this assessment relate to people's ability to connect with banks, stores and so on.

The third set of glimpses which make linking a practice of inclusion emerges as occupational therapists match community resources with assessment information. May's work with a woman referred by her physician for "simple stress management" demonstrates how the three components of linking are interwoven to promote a woman's inclusion in a community from which she had withdrawn. May describes uncovering the woman's home, marital and parenting situation where she was "very perfectionistic". May encouraged her to acknowledge her own needs and ask her family to contribute to the housework so that she might be included once more in community life. In the end, the woman:

... did enlist her kids to help out more and she joined a health club and was going to go in swimming a couple of times a week - with her husband.
(Interview with May, MINTOT01, 1661-1665)

Occupational therapists' wide ranging resource files mean that they may also link people with employment possibilities, volunteer situations, housing options, self help or community support groups and various types of professional services. Linking is based on implicit ethical assumptions that people are worthy and have potential to help themselves and contribute to society³. Linking processes attempt to make compatible connections in which people realize their personal sense of meaning, be included as valued members of specific groups, and participate as citizens who are entitled to decent housing, employment and other community resources.

Besides the work of linking, other glimpses of occupational therapists enabling

³ The three major processes described here as 'linking' also require implicit, invisible narrative reasoning (Mattingly, 1991a, 1991b). The reasoning is complex but produces a practice which appears to be little more than ordinary 'common sense'.

inclusiveness appear occupational therapists' work of advocating with and on behalf of people⁴. While linking tends to promote inclusiveness in local situations, occupational therapy's 'advocacy' promotes inclusiveness on a broader scale. In doing 'advocacy', occupational therapists promote inclusiveness by expanding people's options for participating in communities. Occupational therapists are involved in a wide range of community and social agencies including local Canadian Mental Health Association (CMHA) committees, boards of directors of special recreation services, community groups sponsoring group homes, rape crisis support services, government task forces planning new employment programs, mental health self-help groups, and so on (see Chapters 4 and 6). The point of these activities seems to be to develop greater opportunities for stigmatized people to become part of community life - to become empowered and included in a more just society.

8.5 Organizing Marginal Public Spaces: Confining the Vision

Despite the positive glimpses cited, occupational therapy's practice of enabling global inclusiveness faces an uphill battle. Major constraints appear to be located in the institutional processes of 'discharge', 'follow up', 'sheltered employment', 'social recreation' and the organization of 'special benefits'. Barriers exist as discharge and follow up processes attempt to disconnect people from their involvement in professional mental health services (see Section 8.5.1). Moreover, if one looks at the communities into which people are being discharged and followed up, there are additional barriers. State legislated economic and welfare practices appear to block the inclusion of people diagnosed with mental disorders. Stigmatization and marginalization (Bachrach, 1988; Woodside, 1984) appear to be major barriers for enabling global inclusiveness and social justice (see Section 8.5.2).

⁴ See Chapters 4 and 5 for differences between working with and on behalf of people.

However, before analyzing these specific institutional constraints, it is worth noting that the promotion of inclusiveness is limited, to some extent, by occupational therapists' undeveloped consciousness about the profession's ethical underpinnings. In addition, this feature is constrained by institutional requirements for occupational therapists to categorize and manage safe types of change in medical cases. To explain, some of the glimpses of linking and advocacy are also glimpses of social action which, as we saw in Chapter 4, is officially outside the mandated work of individual case management. In addition, community-based work, which extends beyond the designated location and time frame of programs, is funded mainly through miscellaneous and petty cash funding (see Chapter 6). Furthermore, the institutional practice of risk management (see Chapter 7) discourages occupational therapists from increasing their community involvement with people for fear of increasing professional and institutional liability.

Overall, the picture of occupational therapy, in real terms, is one of stasis. It seems that people and occupational therapists are largely confined to program conditions unless they work outside the officially-sanctioned structure in which they are accountable, funded and protected. To add to this picture of constraint, it is important to remember that people are not even officially constructed as active beings (see Chapter 3) or decision making partners except in personal goals and action (see Chapter 5). People's categorization as 'passive' patients with limited decision making power limits their inclusion as 'active' partners in all realms of society. In themselves, these interconnected features confine occupational therapists' potential for enabling inclusiveness within the existing framework of programs.

Furthermore, the work of enabling inclusiveness is limited because some people have lingering mental difficulties which impede everyday living⁵. Nora describes one woman:

⁵ Previous descriptions of people's mental difficulties appear in Chapters 3.4, 5.5 and 7.5.

Her progress has been really slow because of her illness - cognitive deficits - very hard. Every time we sit down to talk structured budgeting issues, her attention span is really negative for it. (Interview with Nora, NINTOT01, 110-116)

In addition, limitations lie in people's reliance on professional mental health services so much that, as Bev says, people devalue or ignore non-professional programs. Instead, they expect that professional services will "take care of me":

I find that patients⁶ have an excessive dependence on the [mental health services]. There's still that view that: 'when I get sick, make me better. Like don't tell me to change to promote my mental health. When I'm sick, take care of me.' (Interview with Bev, BINTOT02, 461-468)

Even where non-professional support services, such as ordinary, community recreation programs are open to people they do not always use them. As Pat observes:

There are actually recreation programs running [in this community] but people in this program generally don't tend to make use of them. (Interview with Pat, PINTOT01, 33-36)

Pat faces the difficulty of finding ways to enable people to use existing recreation programs which may or may not wish to include these people.

8.5.1 Including Cases in Medical Communities

More powerful barriers to enabling inclusiveness within and beyond programs, though, are the institutional processes of 'discharge' and 'follow up', the last two processes in the sequence of individual case management⁷. In Chapters 3 to 7, tensions which constrain various features of occupational therapy practice were shown to be organized by institutional processes

⁶ Bev's statement shows again how medical discourse dominates practice so much that people are defined as medical patients even when the concern is their inclusion as ordinary citizens in community life.

⁷ The institutional processes of discharge and follow up described here organize the processes of linking and advocacy which, as the previous section describes, constitute part of the everyday work of discharge and follow up.

and practices oriented to managing psychiatric cases in medical conditions. Some tensions which curtail the work of enabling inclusiveness can also be traced to these same institutional practices.

How do discharge and follow up constrain the work of enabling inclusiveness? In psychoeducation programs, people stay only a few weeks or months. In psychosocial rehabilitation programs, people with long term mental disorders stay in programs for years. However, in all transitional mental health programs, occupational therapists work with people in limited locations and over limited periods of time. Furthermore, the mandate is to work with individual cases so that no official time is allocated to enable the social changes required to develop more inclusive institutions and communities. Certainly, occupational therapists are encouraged to recognize people's worth and to encourage "real and natural connections" within programs (see Section 8.4). However, they are encouraging people to become part of an artificial community which is not connected with the real people and conditions which govern their lives. Particularly in psychoeducation programs, people come and go so quickly that connectedness has little time to develop and is painful to break when people are discharged. In essence, programs create and recreate psychiatric communities. Community members are actually cases of mental disorder rather than real active people. Members are connected by their shared experience of being diagnosed with a mental disorder. However, given the diversity of people's actual life experiences, they may or may not discover a real foundation for recognizing worth, developing connectedness, celebrating diversity, or otherwise promoting inclusiveness.

The creation of psychiatric communities is organized by the use of medical categories to coordinate health services. Psychiatric communities are the everyday context in which the "ideological circle" of psychiatric case management is produced and reproduced (Smith, 1990b, p. 44) (see Chapters 4.5 and 6.5). People's experience is reduced to the DSM-III-R problem or diagnostic categories (American Psychiatric Association, 1987) used to coordinate and control

program admission (see Chapter 3). Based on diagnostic facts, individual cases are guided to simulate the decision making and actions of everyday experiences removed from the risk taking of real life circumstances (see Chapters 4 to 7). Discharge completes the circle of psychiatric case management as Bev describes:

We're very much a goal oriented program. So, from the very beginning, we're discharge planning. From the pre-admission interview, we're trying to establish a time line with these people on how long they want to come. (Interview with Bev, BINTOT01, 289-297)

Admission goals are actually part of "discharge planning" which starts "from the very beginning" after the "pre-admission interview". Each case is managed individually with an individual "time line". Official discharge then requires the completion of 'separation' forms with a revised DSM-III-R discharge problem or diagnosis. Discharge problems or diagnoses confirm or adjust the facts which justified admission. Categorization is supported by discharge assessment summaries which are constructed, as are admission assessment summaries, from psychiatrists' discharge assessments integrated with occupational therapy and other 'progress' and 'discharge' notes in health records. The information is derived from observation and other forms of assessment conducted largely within the simulated conditions of programs. Within these simulated conditions, occupational therapists assess people's meal preparation, clerical work, maintenance, brief writing, public speaking or the other occupations. As an example, occupational therapists might observe a person's ability and readiness for real employment as they complete a work contract, handcraft project or meal preparation. Information is interpreted for documentation in occupational therapy notes and health records using guidelines such as the Work Assessment displayed in Table 14. The interpretation for this assessment is based largely on observing work in simulated conditions (see Chapter 6). Furthermore, a person's ability and readiness to work in simulated conditions is typically interpreted with reference to "intellectual considerations", "physical considerations" and "emotional considerations".

Table 14

Work Assessment Categories (Site B)*

Intellectual Considerations **

Concentration

Memory

Reasoning

Judgement

Physical Considerations

Manipulative Ability

Coordination

Speed

Work Tolerance

Quality of Work

Emotional Considerations

* Reproduced from actual document without location identifiers.

** In the actual document, each of these category titles are followed by a set of questions and space for a summary. At the end of the document, "Recommendations" and "Work Area Suggested" are recorded.

This is information which is relevant to occupational therapy but it is also used to fit people into DSM-III-R diagnostic categories. It is true that occupational therapists' (and people's own) knowledge of their lived reality (i.e., their real ability, real work conditions, work history, and real work opportunities) may be observed and recorded in some situations. However, this information is rendered invisible and irrelevant in management records by the diagnostic categories used to define cases and account for the types of cases being managed. Discharge then returns people to a lived reality with 'follow up' recommendations for them to translate their simulated experience into real life.

Since discharge and follow up are processes within the sequence of case management, they are organized with relevance to management interests in accountability. Management is concerned with both quality and efficiency (see Chapter 4). Accountability practices, such as quality assurance, promote adherence to discharge procedures and documentation. As well,

accountability for efficiency promotes discharge as early as possible so that the time (and cost) per case is minimized while the maximum number of cases is managed. Follow up is generally optional unless programs embark on evaluation research to study what happens to people after discharge. Generally, once cases are officially discharged, follow up is not officially monitored. Follow up falls outside that which is held accountable in determining occupational therapy productivity in managing caseloads.

Furthermore, discharge and follow up tend to sustain the medical communities of mental health programs beyond program boundaries. The work of follow up is an attempt to link people, through informal or formal referral, to some type of community support (see Section 8.4). In the programs studied, people may be referred to employment, recreation, financial support or other community resources. But they are almost always discharged with a referral back to the person who made the referral to the program. In all but Site M (where the referring agent may be anyone), this means referring a person back to a physician or other professional. Bev describes how this referral circle works.

[People have been] referred by professional services. So we don't feel that it's our role to cut them off from professional services. We feel that it's our role to refer them back to the referral source for follow up. And if the referral source decides that they want to terminate professional services - if the patient is ready - then they can do it. (Interview with Bev, BINTOT03, 751-761)

Bev's comments point out that transitional mental health programs are not discrete entities in real communities. These programs are part of a professional set of mental health services. People are discharged from one program. But, if they need ongoing assistance (follow up), they are referred to another. This is done using referrals which tend to pass people around amongst various professionals in various types of mental health programs. Rather than promote people's inclusion as worthwhile members in ordinary communities, official requirements for discharge and follow up sustain people's stigmatization as members of a psychiatric community. In other

words, as occupational therapists enable people's inclusion within programs, they reproduce the psychiatric communities required for individual case management. Discharge completes the circle of individual case management by linking people with other psychiatric communities outside transitional mental health programs.

Certainly, occupational therapists make referrals to housing programs, employment projects, recreational activities, support groups and so on where there is no medical involvement. However, these are part of the glimpses already described as 'linking', not the official management of discharge from mental health services. When I asked Bev about extending occupational therapy into the community, the answer was:

I guess the reason would be time. We don't have the staffing to do it. I think it would be very worthwhile. I have a strong belief that the community is where occupational therapy can be best put to use. Where an occupational therapist's skills are best utilized. (Interview with Bev, BINTOT02, 317-3223)

Furthermore, confidentiality legislation, which requires official consent to reveal people's information, tends to maintain a psychiatric circle of referral rather than to forge new community connections. For instance, when occupational therapists make or receive telephone calls from other professionals or community services (as in linking and advocacy), program policies limit them from even acknowledging whether or not a specific person attends the program (see Chapter 5, Table 10, Policy on Confidentiality).

In addition, occupational therapy legislation intersects with psychiatric and hospital legislation to control occupational therapy practice within a medically-insured context. Occupational therapists are unable to stretch follow up beyond medical discharge because occupational therapy and hospital legislation make them legally liable as individual practitioners who must work under medical direction (see Chapters 3.5 and 7.5). Rita explains her legal restriction from continuing to work with a woman 'Joanne' who is expressing fear at the prospect of losing program support and having to find support from a new community worker:

[Rita speaking to Joanne]: You're certainly welcome to call if you need to but hospital policy says that we can't do follow up. We are so busy on the one hand that we can't take on the follow up. But the other thing is that the hospital requires us to have medical coverage. Now I can't imagine that there would be anything happening that you'd want to sue me for. But if anything happens while you're in the [program], I'm under the authority of the psychiatrist. But once you're discharged, then the psychiatrist does not have authority for that. And I can't work without that medical authority. (Observation Notes, ROB09, 841-857, Site R)

Interconnections between discharge policies, accountability, funding, confidentiality legislation, professional referral legislation, and liability insurance legislation create an apparatus which contains occupational therapy's work of enabling inclusiveness within the medical communities of mental health programs. Given these institutional conditions, it is no wonder that community development tends to be discouraged in favour of providing individualized, community mental health services (Leighton, 1982). In the end, the referral circle which sustains the medical communities created by mental health services also perpetuates economic and welfare practices which exclude people from ordinary society if they are members of a psychiatric community.

8.5.2 Perpetuating Exclusionary Economic and Welfare Practices

Furthermore, people who are members of a psychiatric community have a history of being stigmatized and economically marginalized (Foucault, 1965; Lasch, 1977). Therefore, occupational therapists' work of enabling inclusiveness with these people is constrained not only by requirements to manage medical cases within mental health programs but also by state legislated economic and welfare practices. These constraints are particularly visible in occupational therapists' work associated with 'sheltered employment', 'social recreation' and 'special benefits'.

I began to see occupational therapy's connections with state economic and welfare practices in occupational therapists' discussions about people's real lives. All occupational

therapists in the study highlighted people's mental difficulties as only part of their problems. In their talk, therapists tended to describe people, particularly those with long term mental problems, as 'stigmatized' beings relegated to a 'marginalized' life of poverty. As Pat says:

The particular group of people we have at this time - poverty is a big one - not so much psychoses or thought process disorders - at other times in the program there have been people with those difficulties - but emotional upheavals, life crises, events, difficulty interacting with others. Quite a number of people have had traumas in the past that have affected their relationships, their lives so that they decide - for one reason or another - that they need to start dealing with them - get some support. (Interview with Pat, PINTOT08, 437-452)

As Jill points out:

We don't just look at the client in the program. We're always looking at what other things are affecting their performance. So obviously, then, housing is always a big one. Because some of them come from - being out-patients - they have some pretty poor boarding houses. And they're not fed properly and they're cold as well. (Interview with Jill, JINTOT01, 664-673)

Some people in these programs are struggling with problems of basic survival: "housing", "poor boarding houses", being "fed properly", being "cold". They are living marginal lives of subsistence. Poverty is both a product of their marginalization and a constraint which perpetuates their marginalization (Hollingshead & Redlich, 1958). And yet, communities resist accepting these people as valued members. In Nora's words:

Their barriers are fitting into a society that's really geared to a high pace, and people who can function at a much higher level than they are capable of functioning. Our society is really a pretty stressful kind of society. And in most work situations, there's a certain level of productivity expected. There's a certain intolerance for any aberrant behaviours, intolerance for anybody that looks a bit different. There's a lot of stigmatization of anyone who's had a chronic mental illness. So they've got a lot of barriers to face. (Interview with Nora, NINTOT03, 530-546)

Communities are "geared to a high pace" with little interest in including people who are not already part of mainstream society. While professionals attempt to develop inclusive community practices, communities expect professionals to look after those whom communities are unprepared and unwilling to include (Cook, 1988). Community exclusiveness is particularly devastating for

those who have experienced long periods of institutionalization. As Bev says:

We've done a disservice to these folks by discharging them from institutions to their home community. But their home community doesn't want them...If you've had a fracture, you're expected to go back to work. But after you've had a depression or a psychotic episode, going back to work, or going back to your home just isn't the same. (Interview with Bev, BINTOT02, 1331-1484)

People, professionals, governments and communities all perpetuate exclusive practices which leave marginalized people in poverty. People remain excluded because they have little money to participate in society. Moreover, they are included only as a marginal group in employment training, job creation, employment and other economic-related practices through which they might work their way out of poverty.

The real effect of stigmatization and marginalization, then, is not just social exclusion but economic exclusion. People diagnosed with mental disorders are not welcome competitors for employment and associated economic advantages such as housing. In part, professionals who attempt to enable the economic inclusiveness of these people face resistant employers. Occupational therapists, like other professionals find that employers use mental illness as an excuse to exclude those unable to sustain standards set for economic productivity (Ralph, 1983). They also find that employers and governments have a singular idea of productivity so that part-time, shared, supportive and other work arrangements are not widely available (Peitchinis, 1989). Yet, it is not easy to enable people diagnosed with mental disorders to fit within the narrow range of economic opportunities available to them. As Jill explains:

For many of our people, 'work' as the general public would know - the 40 hour work week - for a lot of our people, that's not realistic. So when we do presentations here, instead of 'work', we'll refer to 'productivity' and explain that it's not necessarily the five day work week. But it's the idea of productivity ...the sense of accomplishment, self esteem. Whether it be volunteer work, or working ...for an organization. (Interview with Jill, JINTOT01, 885-900)

Jill, like the other occupational therapists, tends to take a broad view of productive 'work'. But occupational therapists generally find that the work allocated to people diagnosed with mental

disorders is sheltered employment or merely social recreation.

Sheltered employment offers people simulated work which is usually remunerated through incentive rather than real wages. Occupational therapy, in particular, organizes sheltered employment opportunities. Therapists develop these as alternative employment strategies outside the ordinary economic life of a community. As an example, in Site J, there is a carpentry program in which people make lawn chairs, plant boxes and so on for revenue generation (see Chapter 6). But the shop is not allowed to publicly advertise its business nor its sales of goods. Publicity is prohibited because government policy forbids health and other services to compete with private business. Therefore, word of mouth is the only advertising possible. As a non-business, the carpentry program is required to sell its goods at close to the cost of materials with a labour charge not to exceed the incentive wage of a few dollars a week earned by people who are receiving the special benefits of social assistance (see below). People are paid below legislated, minimum wages on the argument that this is therapy rather than employment.

The other classic sheltered employment projects organized by occupational therapists are in hospital industries such as laundry, food services and housekeeping (Driver, 1968). However, once again, occupational therapists organize special, token payment. This work must remain within the realm of therapy which draws on hospital and community philanthropy to provide real experience. These are generally jobs which are too small or insignificant to undermine union labour which retains all real, salaried jobs. For instance, hospital industry is organized into:

...a system of job stations through the hospital, the Community Care Centre and the community. Individuals work alongside staff members or employees as a helper/apprentice performing duties specific to the position as well as learning skills associated with the area of work. Examples of such positions are office helper, laundry aide, grounds maintenance worker, library assistant. (Described in Student Manual, p. 19, 1990, Site J)

This analysis of sheltered employment offers another view of the ideological circle of individual case management (see Chapters 4.5 and 6.5). The institutional and social practices

which organize sheltered employment extend the management of psychiatric cases into ordinary life. Sheltered work processes reproduce stigmatization and marginalization not as intellectual attitudes but as an actual practice in actual conditions. Stereotypical, stigmatizing ideas about the worth and employment potential of psychiatric cases support the legislated separation of publicly-funded health practices from competition with private, profit-oriented economic practices. Mental health policies and union legislation limit the development of revenue generation projects which might include people in real employment. Such policies and legislation reproduce a social hierarchy in which people diagnosed with mental disorders are relegated to low paying or unpaid work and, thus, a low socio-economic class in society. In other words, sheltered employment perpetuates exclusionary economic and welfare practices.

Through the analysis in this chapter, we can see that stigmatizing ideas about mental disorders underpin the creation of facts which assume to represent the employment potential of these people. The employment potential of people diagnosed with mental disorders is assumed to be as low paid lawn chair makers, office helpers, laundry aides and other types of work. Assumptions about employment are transformed into everyday practice through the actual work of developing job stations or other forms of sheltered work. Most sheltered work projects are extracted from actual jobs with little consequence to the economy of a society. Projects are developed by finding small business niches which are unproductive elements of the economy: hand made lawn chairs at low cost, or industrial contracts completed at subsistence wages rather than the union wages which would be required if the work was included in the regular economy. These options are then simulated, often within artificial program conditions, to provide psychiatric cases with simulated employment experience. These people gain experience as office helpers and other low paid work. Based on this experience, people with psychiatric diagnoses are slotted into similar low paid types of employment in real life.

The other work allocated to people diagnosed with mental disorders is social recreation.

As Pat says, when people are not employed:

The program's response has been to provide social recreation programs which have been spearheaded by ot [occupational therapy]. (Observation of Pat, POB30P, 40-42)

Occupational therapists are encouraged to spearhead the development of social recreation programs to keep people busy. Carol describes how she engages people in handcrafts as a form of social recreation which helps people to:

develop some kinds of hobbies or leisure interests for lifestyle changes...if they've been depressed or in some kind of deprived environment or whatever, they haven't had a lot of opportunity to explore options. (Interview with Carol, CINTOT01, 183-195)

I have no doubt that Pat's involvement in social recreation and Carol's approach to lifestyle changes promotes some degree of inclusiveness for some individuals. Furthermore, some municipalities are developing supportive recreation programs so that ordinary recreation includes a diversity of people using support systems such as "buddy" programs. For instance, Carol makes referrals:

...to the city recreation department for more in-depth leisure counselling and leisure sampling. They have a sort of buddy program so if somebody's anxious about going out into the community, that's an organization that will hook up a leisure buddy who will actually go with the person the first few times, until they're feeling comfortable. (Interview with Carol, CINTOT02, 429-439)

It is worth noting that inclusive social recreation approaches, such as buddy programs for new, uncertain players, likely reduce some of the social stigmatization experienced by people diagnosed with mental disorders. Other community members see and hear that these are people with feelings, ideas and abilities which may be similar to their own. However, the focus on social recreation and leisure is diversional. It diverts attention from people's inability to find a suitable niche in which they are considered to be worthy, productive contributors with entitlement to share the power and resources of society. Social recreation likely enhances social inclusiveness. But

the development of social recreation with or for people diagnosed with mental disorders perpetuates their economic exclusion from mainstream society. Discharging people to social recreation without employment relegates these people to play while communities go about their real, economic business.

These economic practices ultimately connect people with welfare practices. Since neither sheltered employment nor social recreation provides sufficient economic return for even subsistence living, people are offered 'special benefits'. These are resources which are organized through state welfare and some voluntary organizations. Special benefits sought from voluntary organizations include special rates for membership at the YMCA/YWCA, low cost social clubs for people diagnosed with mental disorders, and many of the other community connections already described (see Sections 4 of Chapters 4, 6 and 8).

Occupational therapists, sometimes in connection with social workers or sometimes on their own, may help people apply for special benefits organized through the legislated practices of state welfare. Such benefits include 'special needs funding' provided through municipal or provincial regulations for social assistance. Special benefits also include the extra disability allowances available to some people in addition to basic social assistance. Some people are eligible for disability pensions which people claim from private insurance companies or some former places of employment which offer disability severance packages as part of employee benefits. Other special benefits which are usually available to people with a psychiatric diagnosis are pharmacare cards for free prescription drugs. While they are in programs, people can request bus tickets to the program or even monthly bus passes as a special benefit.

As well, occupational therapists help people find grants for 'special interest' groups. Or they work with people and various community workers to locate special funding for recreation, housing and employment opportunities for 'minority' or 'disadvantaged' groups such as people

with disabilities. Various municipal, provincial and federal initiatives have provided special funding competitions for these groups. These funds are generally easier to obtain than to compete for mainstream recreation, housing and employment.

Once again, occupational therapists use 'discharge' and 'follow up' to develop community resources which promote a small degree of inclusiveness by preventing people from living in abject destitution. Special benefits provide an infrastructure of financial resources which foster people's social inclusion within mental health programs and general community activities. However, people are gaining access to 'special' resources while being excluded from sharing the full economic resources of society. Yet 'special benefits' seem to be adjuncts to state economies such that they are conceptually parallel to the 'petty cash' which represents a small token gesture to fund activities which lie outside the main budget of health services.

The evidence presented above shows that many people with long term mental difficulties are economically sustained through a network of sheltered work, social recreation and the special benefits offered by both voluntary organizations and the state. Together, these practices form an interconnected force which perpetuates stigmatization and marginalization. It is the combined, interconnected authority of these actual, everyday processes, not stigmatizing or discriminatory social attitudes alone, which confine occupational therapists' attempts to promote inclusiveness. Jill's experience highlights how these interconnected processes control the exclusion of people from real employment:

Probably the optimal goal for them now is work therapy given the fact that any sort of competitive work or outside work is not only unrealistic but financially unreasonable. So for a lot of them the goal of work therapy is their 'work'. That's the top of the line. (Interview with Jill, JINTOT01, 487-495)

Many people find that they lack the ability to participate in "competitive work" or "outside work". This points to legislated, economic practices which are dependent on extracting the maximum capital from a full time labour force. Those who require part time or supportive

arrangements are not competitive in a marketplace which extracts the maximum labour for the minimum production expense. Together, sheltered work and special benefits are economic disadvantages for people to enter the job market in the low paying types of work which are often the best option available to people diagnosed with mental disorders. Special benefits are actually disincentives to employment. As Jill says:

We got 'Paul' all lined up for the job and he went for the interviews and he got a job. But when he added up the money, he realized that he would actually lose out because he would lose his social assistance benefits. So he turned it down. He would be making less than he is now. (Observation of Jill, JOB02, 297-305)

Paul is economically less marginalized on social assistance supplemented by special benefits than he is in regular employment. For him, employment is not a route out of poverty. He is relegated to poverty by his stigmatizing categorization as a psychiatric patient and his mental inability to hold full time, competitive employment in an ordinary job.

Ironically, sheltered work, special recreation, and special benefits limit inclusiveness while they simultaneously support the deinstitutionalization of people from mental asylums. On the one hand, these processes create positive opportunities. Through them and other aspects of linking and advocacy, occupational therapists seem to enhance people's social integration outside institutions (see Section 8.4). On the other hand, sheltered work, special recreation and special benefits divert attention from the stigmatization and marginalization which people with long standing mental difficulties continue to experience. This contradiction appears to lie in society's commitment to an ethic of philanthropy rather than an ethic of inclusiveness.

Philanthropy is usually associated with volunteer services and private acts of charity. But the ideas of philanthropy underpin the use of sheltered work, social recreation and the special benefits provided through state legislated welfare practices. It is the ideas of philanthropy which connect these into an alternative economic apparatus which perpetuates people's economic exclusion from ordinary society. These are all state sanctioned forms of charity. I say this

because these processes provide economic benefits which support a marginal existence from which there is no escape, even through employment. None of these processes recognize that people's worth gives them entitlement to an equitable share of the power and economic resources of society. They suggest an entitlement to special opportunities which are restricted to special psychiatric cases.

Analysis here shows that the philanthropic organization of special opportunities confines occupational therapy's commitment to enable inclusiveness. Occupational therapy is restricted to enabling people to take advantage of stigmatizing, marginalizing opportunities. Sheltered work, social recreation and special benefits are hierarchically controlled, in part, by legislation which allocates this work to mental health services. However, these processes are also hierarchically controlled by legislated economic and welfare practices designed to provide charity to indigent people while maximizing profits for those who control the power and resources of society. Ideas of philanthropy carry no ethical obligation to organize the equitable sharing of power and resources. While occupational therapy enables some inclusiveness within programs and special niches of society, occupational therapy is confined to being a 'domesticating practice' rather than a 'liberating practice' (Freire, 1985). By this, I mean that occupational therapy is organized to domesticate people through sheltered employment, social recreation and special benefits so that they do not challenge the hierarchical, economic order of society. This contrasts with liberating people to celebrate their diversity and transform economic and welfare structures which currently perpetuate their stigmatization and marginalization.

It seems that professional and management practices interact with economic and welfare practices to prevent occupational therapy from promoting inclusiveness in economic as well as social spheres. Together, these interconnected practices appear to form an organizationally "impregnable" apparatus (Smith, 1990b, p. 94). The impregnability results from the

interconnectedness of multiple practices supported by legislation which embeds them in the impersonal, objectified working of the state (Gough, 1979; Panitch, 1977). No individual or group of individuals within any particular government department or program is responsible for the multiple, intersecting practices which constitute this apparatus. And yet, through this anonymous, complex organization seems to be socially mandated to manage rather than enable the empowerment of mentally disordered people who might compete for scarce resources in ordinary communities.

Furthermore, this anonymous apparatus organizes the actual processes and practices of professionals such as occupational therapists who are employed in publicly funded programs. While governments and communities espouse social integration, empowerment and social justice for disadvantaged groups, they simultaneously limit the inclusiveness required for empowerment. Government policies, budgets and legislation restrict the development of programs which are alternative to those already funded by government. As May states:

If you're looking for money, and you're advocating that the provincial government...I mean, that's not really...it should not be done. Really. There's an unwritten law here...as a lay person one could advocate for these things. Do it on your own time. You're allowed to do whatever kind of volunteer work you want. (Interview with May, MINTOT01, 1242-1286)

Government seems to take care to avoid competing with private business. But then, private business seems to dominate and control government. Most readers will have seen reports of small businesses which have received government funding to include people with disabilities. While such businesses are encouraged as a means of promoting people's development and integration within society, they are often pressured to shut down when they begin to compete with the local business community.

Reflection on the evidence here points to the dominance of a market ethic which values the economic 'bottom line' more than an ethic of global inclusiveness. This thesis does not

attempt to construct institutional ethnographies of housing, employment, education, social welfare, banking, business and other functions in society. But my expectation is that analyses would show how these functions are dominated, to varying degrees, by legislated economic concerns for market profitability rather than social concerns for inclusiveness. However, this study does show how philanthropic (hierarchical) economic and welfare practices organize sheltered employment, social recreation and special benefits. These three alternatives to real employment are mechanisms through which occupational therapists can enable some social inclusiveness. However, they leave occupational therapy with little potential for enabling people's economic inclusion in society.

In Atlantic Canada in the 1990's, I would be remiss in analyzing the work of enabling inclusiveness if I overlooked recessionary economic conditions. Limited funds mean that there is little public space in which occupational therapy might promote an ethic of inclusiveness in job creation, housing and all the other aspects of economic life other than through sheltered work, special recreation and special benefits. Jobs are scarce even for young, educated, white, middle class males who, as a rule, are the most employable people in Canadian society. Those who can only manage part-time work, need special supervision, or have disrupted employment histories are likely to have the most difficulty competing especially if they lack decision making or other skills. In these conditions, state philanthropy in social programs tends to be questioned leaving stigmatized, marginalized people vulnerable to losing even that type of support.

In the end, occupational therapy's potential to enable communities to develop employment and other niches for people with mental disorders is severely confined both within and beyond programs. As Nora says:

Occupational therapists could use a little radical shift. We didn't start [transitional mental health] programs, even though it's all part of our philosophy. We're not sort of at the leading edge of social advocacy or anything like that...occupational therapists have adapted to quality assurance and all that kind of stuff...We're kind of being socialized into working in the system and accepting that. (Interview with Nora, NINTOT03, 747-808)

There is undeveloped potential in occupational therapy which, as Nora states, needs a "radical shift" in practice to match "our philosophy". However, at present, the profession has "adapted to quality assurance and all that kind of stuff" and is "socialized into working in the [psychiatrically-managed] system".

Although occupational therapy engages in chores, linking and advocacy which may create some niches of inclusiveness, these processes seem to support the development of parallel, segregated, marginalized opportunities, primarily within the psychiatric communities perpetuated by professional mental health services. Sheltered employment, social recreation, and special benefits tend to keep people stigmatized and on the margins of society. These community practices sustain a form of apartheid for people diagnosed with mental disorders.

8.6 Summary

In an ideal empowerment-oriented practice, there is an ethical commitment to global inclusiveness which is consistent with social justice. Inclusiveness is defined here as a form of spirituality. This is a spirituality based on beliefs in the equal worth and power of people as individuals who are valued as interconnected members of a community of individuals who may also be connected with a greater spiritual power. There is evidence in literature and practice that this ideal ethical commitment forms the foundation of occupational therapy. Occupational therapy addresses spirituality in terms of people's worth and meaning in society. In practice, occupational therapists demonstrate their belief in people's worth and meaning as genuine compassion, acceptance, respect, caring, and faith that people are worthy, contributing members

of society. Diverse contributions are emphasized as important even when they seem as insignificant as cutting the onions for a group meal. In chores, inclusiveness is fostered through shared responsibility on a common project. Linking and advocacy (related to the work of discharge and follow up) display possibilities for finding existing niches and creating new opportunities for including people diagnosed with mental disorders in ordinary society.

But interconnected professional, management, economic and welfare practices confine the development of this feature in occupational therapy. Occupational therapy is restricted, in part, by managing psychiatric cases largely within the psychiatric communities organized to accomplish psychiatric case management. As well, people are discharged as quickly as possible in order to demonstrate institutional efficiency. These processes are interconnected with others which confine the work of enabling inclusiveness largely within the risk controlled conditions of program locations and time frames. Confidentiality restrictions and the absence of malpractice insurance coverage outside programs also serve to confine this work to the protected conditions of program facilities.

Interacting with professional and management constraints are stigmatizing and marginalizing economic and welfare practices. People with long term mental disorders often live in poverty. Yet there are few viable, employment options for this group to work itself out of poverty. Instead, sheltered work, social recreation and special benefits seem to divert these people from demanding an equal share of the power and economic resources of society. The ideas of philanthropy underpinning charity and state legislated economic and welfare practices perpetuate stigmatization and marginalization. Philanthropic ideas not only form stigmatizing attitudes, but they organize the actual processes and practices which govern everyday life. Sheltered work, social recreation and special benefits (provided privately or by the state) are all forms of charity which are hierarchically controlled. They support people who have been

diagnosed with mental disorders as stigmatized recipients on the margins of society rather than as worthy contributors who are included within society.

In its connections between professional, management, economic and welfare practices, occupational therapy is confined to perpetuating a kind of apartheid for people diagnosed with mental disorders. Occupational therapy's promotion of inclusiveness is submerged by the institutional organization of individual case management within program facilities. Occupational therapy's promotion of inclusiveness within society is further undermined by powerful economic and welfare practices which perpetuate the stigmatization and marginalization of people diagnosed with mental disorders.

CHAPTER 9

ENABLING EMPOWERMENT OR MANAGING MEDICAL CASES?

A CENTRAL TENSION

9.1 Introduction

Chapter 9 consolidates the argument put forward throughout Chapters 3 to 8 that occupational therapy's potential for enabling empowerment is largely submerged. It brings a single focus to my claim that tensions which surround core features of this profession constrain the development of its potential as an empowerment-oriented practice. When analyses of six core features (Chapters 3 to 8) are grouped, analysis across each of the features shows a central, overall tension. Each chapter reveals glimpses of possibilities for occupational therapy to develop towards an ideal practice oriented to enabling empowerment. However, powerful institutional constraints almost submerge these possibilities. Despite glimpses of an ideal practice, occupational therapy is primarily oriented to managing medical cases.

To present the overall picture, the chapter brings together, first, the 'possibilities' for enabling empowerment which consist of glimpses of an ideal practice. Then, second, it brings together the 'constraints' which consist of the institutional processes oriented to managing medical cases. These two sections display contradictory patterns of practice for educating adults diagnosed with mental disorders: one pattern is based on enabling these people to share power; the other is based on controlling power. The third section analyzes occupational therapy's compromise and resistance in the face of institutional constraints.

9.2 Possibilities for Enabling Empowerment

Each of the six preceding chapters displays one core feature of an ideal empowerment-oriented practice. Together, these features portray a set of interconnected work processes which I call "Enabling Empowerment" (see Table 15). The image created by bringing glimpses together is of an empowerment-oriented practice which is not a single technique nor a series of unrelated activities.

In summary, "Enabling Empowerment" is the work of enabling people to share power. This work is based on a definition of power as a generative human resource which is distributed through the institutional processes and practices used to govern society. Using this definition of power, empowerment is defined as an interconnected set of personal and social processes through which unempowered people gradually share power in society (see Chapter 1.2). Based on these definitions of power and empowerment, the educational work of enabling empowerment recognizes that people have the power to act and educates them to engage in an interconnected set of personal and social processes. This is an educational practice oriented to enabling people to become equal decision making partners in transforming powerlessness in their personal lives and society. In enabling empowerment, people who are not empowered are challenged and guided, individually and collectively, through the risks of incorporating critical reflection with real action to transform themselves and society. Moreover, the work of enabling empowerment fosters development of a public ethic and the institutional, economic, welfare and professional practices required to foster human growth within an inclusive society. In essence, enabling empowerment is the educational work of building a society which actually shares power and resources equally and celebrates the diversity of people's characteristics and practical contributions to that society. Therefore, an ideal practice enabling empowerment resounds with a broad but pragmatic vision of the practical possibilities for developing social justice.

Table 15

**Enabling Empowerment:
An Ideal Vision of Sharing Professional Power**

Recognizing Persons' Power to Act

Recognizing the Interdependence of Persons in Society

Collaborating in Decision Making Partnerships

Educating People to Act in the Real World

Enabling Risk Taking to Produce Transformative Change

Promoting Inclusiveness

Using this definition, possibilities for implementing an ideal practice oriented to enabling empowerment include but extend beyond face-to-face interaction. Therefore, an ideal practice cannot be realized through professionals', managers' or others' good intentions to support empowerment. Although necessary, it is insufficient to enable people to feel and act empowered unless possibilities for enabling empowerment are institutionally organized.

Six features in an ideal practice, condensed from analyses in Chapters 3 to 8, provide a profile of 'possibilities' for developing an ideal empowerment-oriented practice. Possibilities for actually developing an ideal practice are presented in the form of glimpses in occupational therapy literature and actual practice in transitional mental health programs. Critical analysis of practice shows these glimpses to be severely constrained. However, they do exist. They offer positive practical examples of an ideal practice which has survived despite the dominant practices described in Section 9.3.

9.2.1 Glimpses of an Ideal Practice

Recognizing person's power to act (see Chapter 3): The foundation for a practice with potential to enable empowerment is recognition that all people are 'persons' who have power to act in the world. An ideal practice is person-centred, meaning that people who have been historically marginalized become recognized as active people because all people are autonomous and worthy humans with the capacity to act in their own lives and society. Development of this person-centred practice is fundamentally dependent on officially conceptualizing and categorizing people as active persons.

Occupational therapy literature and practice offer glimpses which illustrate some possibilities for developing this core feature of an ideal practice. Possibilities exist where people are recognized as active clients or, as in Site N, members of a clubhouse. As well, glimpses of this feature occur where dress codes, facilities and schedules demonstrate recognition that people have the power to be active. There are glimpses in occupational therapy's conceptualization and categorization of people as having the power to act in everyday occupations such as cooking, leisure and employment. Glimpses of possibility also lie in official recognition, in program descriptions, that people have the power to act in their lives. Occupational therapy highlights this feature nationally by officially declaring this to be a client-centred practice.

Recognizing the interdependence of people's actions (see Chapter 4): Based on recognizing that people have the power to act in their lives, an ideal practice incorporates a related belief: that people's actions are interdependent, being shaped within a local and broad social context. People's actions are interdependent, in part, in that they are shaped by the interactions and material conditions of everyday life. However, people's actions are also interdependent in that they are shaped by the institutional processes and practices which govern everyday life. These institutional processes and practices include funding mechanisms, public

policies and laws. Therefore, an ideal practice enables people to address personal goals through individual action and to connect these with goals to change local and institutional practices through social action. To coordinate and control an ideal practice related to this feature, documentation is used to make practice accountable for the quality and efficiency of connecting individual and social action.

Occupational therapy literature and practice provide historical and contemporary examples of recognizing the interdependence of people's actions in society. Even though practice emphasizes individual goal setting and action, there are glimpses of possibility for developing this feature where occupational therapists enable people to engage in local and broad social action. In some instances, occupational therapists themselves engage in social action on behalf of people by working on committees and boards of directors. However, in other instances, occupational therapists coach people to write briefs and speak publicly about mental health services or difficulties finding housing and employment. Glimpses of possibility are enhanced where position descriptions and workload measurement officially include social action as categories of institutionally-sanctioned work.

Collaborating in decision making partnerships (see Chapter 5): A third core feature in an ideal empowerment-oriented practice is that people are partners in collaborative decision making. An ideal practice enables people to share decision making power through horizontal rather than hierarchical processes. In an ideal practice, people, professionals and management hold equal power in making decisions about everything from everyday practice to the professional and institutional organization of that practice.

Occupational therapy literature and practice illustrate possibilities for developing this feature. Glimpses of possibility exist in a strong commitment to respecting the worth of individuals and to collaborating with people rather than providing services to them. Although

this feature is complicated by some people's real mental difficulties in problem solving and decision making, there are also glimpses of collaboration where people are included as partners in making decisions about their goals and the coordination of their cases. These glimpses are particularly evident where team meetings include people in making decisions about their situations. Furthermore, these glimpses are enhanced where there is an emphasis on people choosing to attend and participate in programs, and where there is conscious resistance to telling people what is best for them by asking what people think would be best. Glimpses of possibility are extended where people are encouraged to collaborate in program planning and in evaluating their satisfaction with programs.

Educating people to act in the real world (see Chapter 6): The fourth feature presented in this ideal vision is that an empowerment-oriented practice has a two-part educational mission which grounds practice in people's real life situations. One part of practice educates individuals to incorporate critical reflection with the real actions required for everyday living. The other part of practice educates people, individually and collectively, to incorporate critical reflection on society with real social action to change institutions and society overall. In an ideal practice, there is an interplay between program philosophy and funding processes which structures the location and time frame of practice so that people are guided to transfer learning from simulated to real experience.

Glimpses of possibility for developing this feature exist where people are educated to critically reflect on their feelings and thoughts about power and to incorporate reflection with real action in occupations such as meal preparation, work projects or leisure pursuits. Further possibilities are visible where people are involved in social action in real situations. Possibilities seem to be greatest in programs conducted in real kitchens, work areas and recreation facilities. However, in both psychosocial rehabilitation and psychoeducation programs, practice is consistent

with an ideal empowerment-oriented practice where people are initially be guided to codify and simulate experience away from the complexities of real life but they are supported as they transfer learning from simulated conditions to real life circumstances. Petty cash and small revenue generation projects offer examples of financial mechanisms which extend practice into real life space and time beyond the day time structure of programs in specific facilities.

Enabling risk taking to produce transformative change (see Chapter 7): Risk taking is necessary for people to develop empowerment in the real world. An ideal empowerment-oriented practice enables people to take the risks required to transform themselves and society. People are challenged and guided as they take the risks of transforming their personal perspective and competence so that they feel and act empowered in everyday life. Furthermore, practice enables people to risk transforming institutional and social practices which undermine their empowerment. In addition, an ideal practice is accountable for enabling risk taking as well as protecting people's safety. People and professionals are both accountable for being decision making partners who share the responsibility and liability for risk taking.

This feature, like previous ones, can be seen as glimpses in occupational therapy literature and practice. There are glimpses of possibility where practice guides people through graduated, just-right-challenges. For instance, people are guided through graduated challenges in which they take the social risks of attending stigmatized programs, the physical risks of using potentially dangerous materials, and the psychological-spiritual risks of exposing their individual powerlessness in program sessions. Possibilities for people sharing responsibility for risk taking are present where they are included in decisions about their readiness for taking risks in everyday situations. These glimpses have institutional support where program descriptions encourage people to take responsibility for making change and dare people to develop a future which is different from the past.

Promoting inclusiveness (see Chapter 8): The foundation of an ideal empowerment-oriented practice is spiritual in that there is an ethical commitment to enabling global inclusiveness. Here, a view of power and empowerment as a generative resource is paramount. As a foundational feature, this ethical commitment shapes rather than adds to an ideal practice. There is a commitment to include people since they have the power to act as worthy decision making partners in society as well as their personal lives. This ethical commitment emphasizes the connectedness of individuals whose actions are interdependent in face-to-face interaction and in shaping the institutional functions in society. Ultimately, a commitment to global inclusiveness directs an ideal practice to enable people to risk the types of transformative change required to share power and resources in a just society. Development of an ideal empowerment-oriented practice, then, depends on organizing official professional, management and community practices around an ethic of inclusiveness.

As with the other features, there are glimpses of this feature in occupational therapy literature and practice attending to people's 'spirituality'. Possibilities for developing this feature exist where spirituality is an explicit concern for people's experience of personal meaning and their integration as worthy members of society. Glimpses of possibility are shown to lie in emphasizing the worth and power of people within the communities created within transitional mental health programs. Glimpses are particularly evident where people are interconnected through their shared contributions to meal preparation or the chores of maintaining the plants, coffee and other aspects of running programs. Occupational therapists actively support people's inclusion in society by engaging in linking and advocacy as part of their work of discharge and follow up. This work offers glimpses of possibility as occupational therapists promote the inclusion of people with mental disorders in ordinary housing, employment, recreation and other community situations.

9.2.2 Three Arenas of Possibility

Overall, occupational therapy's mental health work illustrates glimpses of possibility for developing an ideal practice in three arenas: conducting everyday practice; structuring specific programs; and organizing professional, institutional and community conditions.

In the arena of everyday practice, possibilities for developing an ideal empowerment-oriented practice exist where occupational therapy recognizes people's active power as collaborative decision making partners in transforming themselves and society. Possibilities also exist where occupational therapists challenge and guide people, individually and collectively, to take the risks of incorporating critical reflection with action in real everyday situations. This means that possibilities are greatest where occupational therapists engage people in the real occupations which are relevant to their lives. Furthermore, possibilities are greatest where occupational therapists are explicit in emphasizing a particular discourse and practice, including: that they work with people as active persons, whose individual and social actions are interdependent in shaping the local and social context. There are possibilities where occupational therapists talk about and actually collaborate with people as decision making partners who are engaged in real occupations. Additional possibilities are displayed where occupational therapists organize just-right-challenges which involve people in risk taking to transform themselves and society. Other glimpses are present where occupational therapists attend to people's spirituality by promoting inclusiveness so that people who have been stigmatized and marginalized become valued members of their communities.

In designing and organizing specific programs, possibilities for developing an ideal practice exist where occupational therapists structure simulated and real life space in locations and with the equipment and supplies for engaging people in real occupations. Some possibilities also exist where occupational therapists structure time to resemble real day time employment with

flexibility to respond to the temporal diversity of people's real life needs. Glimpses of occupational therapy using petty cash and cost-recovery revenue generation funding offer modest possibilities for enabling people to incorporate critical reflection and action in their real life situations. In all, the possibilities for developing an ideal mental health practice are shown to be greatest where occupational therapists design programs which identify and organize people as active participants in the occupations of their real lives.

The third arena is the institutional, economic, welfare and professional practices which organize society. This organizational arena presently offers the fewest and weakest glimpses of possibility for developing an ideal empowerment-oriented practice. Consistent with an ideal empowerment-oriented practice, the institution of mental health services sanctions program descriptions which describe people as active participants who define their own goals, manage their personal lives, and contribute to planning the day-to-day activities within programs. Other glimpses exist in position descriptions and a workload measurement system which officially supports occupational therapy's involvement in defining institutional policies and procedures on behalf of, and in some circumstances, actually with people diagnosed with mental disorders. Possibilities also exist where program philosophies (particularly in psychosocial rehabilitation programs), supplies budgets, petty cash and revenue generation policies support people while they incorporate critical reflection with real action. These glimpses are consistent with an ideal empowerment-oriented practice where occupational therapy is philosophically and financially supported to guide people through transitional learning until people transfer simulated experience into real individual and social action in the locations and times which are relevant to their lives. Transitional learning is most supported where official discharge planning and follow up procedures are used to promote people's inclusion in the ordinary housing, employment, recreation and other resources of society.

Beyond mental health services, economic and welfare practices offer glimpses of possibility where transitional housing, employment and recreation are publicly funded and people are included as active decision making partners. In this study, the most positive glimpses seem to be that there are a few sheltered work programs which support transitional learning which may, for some people, result in employment, and social recreation programs are gradually including people with mental disorders. However, special benefits are also available through state welfare programs or voluntary organizations so that people can use buses, purchase medication and attend training programs which may support their involvement as worthy members of society.

Within occupational therapy, there is a glimpse of possibility in this profession's official national commitment to client-centred practice. Although the definition of client-centred practice is still developing, this client-centred claim refers to occupational therapy's officially recognizes people as clients who are active participants and partners in making decisions in practice and their own lives and communities. Where legislation does not require occupational therapy to be directed by physicians, there are also possibilities for occupational therapy to declare its interests in enabling people to have jurisdiction over the occupations which give meaning to their lives.

9.3 Constraints on Enabling Empowerment

The other set of processes displayed in Chapters 3 to 8 differs from the first set. As a set, these are interconnected processes which I call "Managing Medical Cases" (see Table 16). When examples of these processes are brought together, they form an image which is contradictory to the work of "Enabling Empowerment" (see Table 15). Like enabling empowerment, managing medical cases is not a single technique. Nor is each process a separate, unrelated entity. These processes form an alternate pattern of human interaction and action to that which constitutes the work of enabling empowerment.

In summary, "Managing Medical Cases" is the work of defining and controlling the power of individuals who have been diagnosed as medical cases. This work hierarchically coordinates and controls the actions of cases in the protective conditions of medical institutions. In managing medical cases, there is a commitment to individualism and the protection of professional and institutional power. Underlying this work is a view that power is a finite object which needs to be controlled. Therefore, empowerment is also viewed as a finite object which can be acquired and controlled through management.

<p>Table 16</p> <p>Managing Medical Cases Processes for Managing Professional Power</p> <p>Creating Medical Cases</p> <p>Individualizing Case Management</p> <p>Controlling Decision Making</p> <p>Managing Education Using Simulated Action</p> <p>Managing Risk and Liability</p> <p>Preserving Exclusion</p>

The work of managing medical cases is observable in face-to-face interaction but is organized beyond everyday situations. Like the processes of enabling empowerment, this form of management is not a matter of professionals' or managers' personal preference for controlling rather than sharing power. As described (see Section 9.2.1), there are glimpses of possibility for developing an ideal empowerment-oriented practice in which people are encouraged to be active partners as members of a community which makes decisions about programs. Therefore, analysis of the work of managing medical cases does not show individual therapists dominating passive

patients. Instead, it shows how the work of managing medical cases is organized by professional, institutional, economic and welfare practices within the provincial and federal system of professional mental health practices which are connected with mental health services in Canada.

Six processes used to manage medical cases, condensed from Chapters 3 to 8, provide a profile of 'constraints' which limit the development of an ideal practice oriented to enabling empowerment. Each description highlights and illustrates the essential character of each constraining process using examples from occupational therapy's mental health work.

9.3.1 Managing Medical Cases

Creating medical cases (see Chapter 3): One fundamental process in managing medical cases is the transformation of (active) people into (passive) objects of medical treatment. Medical cases are created by diagnosing pathological segments of holistic people. Fragmentation and objectification occur when active people are defined as 'patients' which fit categories of pathology such as mental disorders. The creation of medical cases both displays and organizes practice based on a paradigm of professional control and patient compliance. This relation of control-compliance is textually mediated through the conceptual framework provided by medical diagnostic categories (Smith, 1990a). The key institutional processes used to create medical cases are 'assessment' and 'admission'. Admission to health services is restricted to medical cases which have been officially assessed and categorized as medical patients. Restricted admission is mandated by provincial and federal policies and laws which grant funding only for health services provided to medically-defined cases.

Occupational therapy practice shows how the process of creating medical cases undermines processes which recognize persons with active power. Recognition of people with active power is undermined by the official categorization of cases by psychiatric diagnosis.

Although occupational therapists may assess people's ability to be active in everyday life, only the objective categorization of psychiatric problems or diagnoses activates the documentary process of admission. In health records, the information from diverse professional assessment processes is synthesized into an official assessment summary. This summary consists of a psychiatric interpretation of the information required to explain why a person is categorized as a particular problem or diagnosis. Provincial, professional and institutional legislation in most provinces contradicts occupational therapy's recognition of active people by defining occupational therapy as a practice with medically diagnosed patients.

Individualizing case management (see Chapter 4): A key process in managing medical cases is 'individual case management'. This is a sequence of processes designed to produce objectified management. Individual case management rests on the documentary creation of cases as categories of individual medical diagnosis. The individual actions of cases are managed through the processes of case management, particularly 'goal setting' and 'case coordination', as follows: from the lived reality of their holistic, contextual lives, people (cases) identify problems and goals for individual action which is managed by documenting progress on these goals; documented facts about individual problems, goals and action are used to account for the quality of the process of individual case management. Furthermore, facts about the numbers of individual cases and aggregates of individual cases (i.e., caseloads) are entered into a Management Information System (MIS); MIS facts are used to account for the efficiency of managing individual cases. This objectified management produces accountability for work without the requirement of face-to-face supervision. Individual case management also individualizes decision making, education, risk taking, discharge and follow up (see subsequent sections).

Analysis of occupational therapy shows how a practice which actually includes individual and social action is institutionally narrowed to emphasize individual action. Ideas and practices

around independence locate responsibility for action in individuals. Then, individual action is managed through individual problem identification, goal setting and case coordination. Management is documented and made accountable in individual health records which are audited for 'quality assurance' against national hospital accreditation standards. MIS information on cases and caseloads is analyzed to account for the efficiency of individual case management. Accountability for the efficiency of individual case management determines program funding since federal government transfers to provincial government health budgets are calculated on past and projected costs per patient/case managed per month and year.

Controlling decision making (see Chapter 5): The work of individual case management is governed by a hierarchy which is particularly visible in processes of 'decision making'. Decision making is a central process of coordination and control in the objectified management of cases. Control is exercised through an institutionally-organized decision making hierarchy as follows: at the top of the hierarchy, those who govern decide which work processes are relevant to that institution and which facts are required to make this work accountable; workers at various middle levels of the hierarchy are allocated the actual work of the institution; these same workers do the documentary work of interpreting which facts are required to account for the quality and efficiency of their actual work; based on documented facts, those who govern the institution make decisions about the ongoing relevance of the actual work and its documentation; those who govern also create a record of their decision making in a variety of documentary forms including policies, procedures, budgets and legislation; these same people govern the institution through position descriptions which require middle level workers to comply with institutional policies, procedures, budgets and legislation.

Occupational therapy literature and practice display how collaboration is contained by the hierarchical decision making structure of mental health services. Those who govern have defined

the primary work of mental health services as that of managing medical cases. Cases are allocated individual responsibility for defining personal goals and acting on those goals, not for being equal decision making partners in controlling mental health services. Furthermore, occupational therapists and other professionals are accountable for the work of managing the decision making and actions of cases by documenting this work in individual health records and the MIS. Compliance with the policies, procedures and legislation which regulate this work is incorporated into occupational therapy position descriptions. Hierarchical control of mental health services is also sustained by people's own reliance on professional management, their lack of knowledge of the system, and their (and professional) requirements for confidentiality.

Managing education using simulated action (see Chapter 6): The objectified processes which create and control individual medical cases also shape educational practices. Education is structured to produce the types of facts which are relevant to the objectified management of individual medical cases. To do this, case problems and goals which are identified for accountability and decision making are also translated into educational needs. These problems/goals/needs are addressed as educational objects. Educational programs are then structured in conditions (i.e., program philosophy, locations, materials and time frames) which primarily support simulation of actions relevant to objectified behavioural needs.

Despite glimpses of occupational therapy engaging people in real occupations, practice is distorted to favour simulation. In psychoeducation programs, the philosophy and funding structure simulation activities, such as role plays and discussions primarily within the simulated space and five day a week time conditions of programs. Even in psychosocial rehabilitation programs, the philosophy and funding structure real occupations but these are conducted largely within fixed program facilities and time schedules. Regardless of program philosophy, official budgets include only small amounts of funding for program equipment, materials and supplies

and very little transportation and other expenses to educate people in real community situations. Petty cash and revenue generation provide some funding flexibility but are adjuncts to the official budget process. Overall, practice is not structured to educate people to incorporate reflection with real action. By being accountable for the quality and efficiency of managing individual cases, practice is essentially confined to using scheduled simulation activities within program facilities without enabling people to transfer simulated experience into real life.

Managing risk and liability (see Chapter 7): The program philosophies and funding processes which interact to emphasize simulation are also interconnected with the management of risk and liability. Risk is controlled, in part, through documentary processes called 'risk management'. These documentary processes consist of policies and position descriptions which officially declare an institution's responsibility for protecting the safety of those who use the services of that institution. Policies also define the types of incidents and crises which require documentation to create legal evidence which could be presented as the professional and institutional defense against a claim of negligence or malpractice. Besides the documentary processes of risk management, risk is also managed through intersecting institutional processes. Institutional processes which objectify people as medical patients/cases limit people's control to their personal behaviour and reduce the risk that active people might challenge professional and institutional practices. These processes are also connected with those which make practice accountable for managing individual cases within the safety of simulated program conditions. These intersecting processes shape the whole institution to control rather than support risk taking.

The processes of risk management do not explicitly limit occupational therapy's work in enabling risk taking. However, they subdue its educational mission by encouraging risk taking primarily in safe activities and situations. Risk is managed by allocating responsibility to professionals (including occupational therapists) for documenting incidents and crises in the same

health records which are used to account for the quality of occupational therapy and other practices. Risk taking is also subdued by policies and legislation which make professionals and institutions liable for protecting people's safety but not for enabling risk taking. No comparable legislation exists to make people legal partners rather than legal adversaries in the management of risk. Intersecting with these documentary processes of risk management are the institutional processes which emphasize individual case management in the safety of simulated conditions where risk is controlled.

Preserving Exclusion (see Chapter 8): Mental health services appears to be committed to case management rather than inclusiveness or empowerment. The commitment is particularly visible in the processes of 'discharge' and 'follow up'. Mental health programs serve people who share the common experience of being diagnosed as a category of mental disorder. People are discharged from programs as quickly as possible, generally to other mental health services. There is a referral circle which keeps people within the stigmatizing and marginalizing community of people known as psychiatric cases. The primary alternatives to this referral circle are to link people with services which provide people with some social and financial support but which perpetuate their stigmatization and marginalization within society.

Occupational therapy literature and practice show how the work of promoting inclusiveness is seriously curtailed by professional, management, economic and welfare practices. Psychiatric cases are primarily managed within the psychiatric communities of transitional mental health programs and discharged with referrals for follow up by other mental health services. Beyond programs, practice links people with special philanthropic resources such as sheltered employment, social recreation and special benefits. These initiatives perpetuate the economic marginalization of people since they offer charity but not the inclusion of people in ordinary jobs, housing, education, recreation and transportation. Compounding these exclusionary practices are

confidentiality legislation and recessionary economic conditions which constrain psychiatric cases in the competition for scarce resources.

9.3.2 Three Arenas of Constraint

Despite glimpses of possibility for developing an ideal practice in three arenas of practice, occupational therapy's mental health work is almost submerged by managing medical cases. Submersion occurs in: conducting everyday practice; structuring specific programs; and organizing professional, institutional and community conditions.

In the arena of everyday practice, occupational therapy's recognition of people's active power as collaborative decision making partners is submerged by describing and categorizing people as patients or cases with mental disorders. Professional attitudes of 'knowing best' for people control collaborative decision making even within the realm of personal goal setting and case coordination. Occupational therapy's practice of challenging and guiding people to engage in real life occupations is subdued and distorted by emphasizing the simulation of behaviour in simulated conditions. As well, the work of enabling social change is narrowed to emphasize individual case coordination within the facilities, time frames and documentary requirements of programs. This emphasis means that the work of enabling inclusiveness is confined to enhancing the inclusion of medical cases in medical communities and the economic margins of society.

In the second arena, structuring specific programs, possibilities for incorporating critical reflection with real action are submerged by philosophies and funding processes which confine practice largely to program facilities and weekly schedules. By confining practice to the designated program space and time structure, occupational therapy is distorted and diverted from enabling people to engage in the occupations which are relevant to people's real lives. The structure of petty cash and cost-recovery revenue generation outside official budget categories

means that engagement of people in real occupations is officially recognized only as a marginal form of practice. Occupational therapy's mental health work seems to be particularly submerged where practice is structured by the psychoeducation philosophy and practice of case management.

In the third arena, mental health management, economic, welfare and occupational therapy's own professional practices all submerge glimpses of possibility for occupational therapy to enable empowerment. Occupational therapy's national commitment to client-centred practice is virtually submerged by the organization of practice around medical diagnostic categories. As well, the organization of practice around medical diagnostic categories confines collaboration since medical cases are passive objects rather than active decision making partners. Furthermore, the organization of practice around medical diagnoses makes occupational therapy accountable for managing only those cases which have been medically diagnosed.

While the organization of practice around medical diagnoses produces one set of constraints, another set of constraints is produced by defining the primary function of practice as individual case management. The work of individual case management is coordinated and controlled using the hierarchical decision making processes of objectified management. In mental health programs, the coordination and control of individual case management is based largely on documentary facts in individual health records and management information systems. These facts are used to make occupational therapy accountable primarily for managing individual cases within program facilities and schedules. Therefore, individual case management narrows and distorts occupational therapy's work of incorporating critical reflection with real individual and social action. Individual case management also narrows and distorts practice by making it accountable for protecting people's safety but not for enabling people to take the risks of transforming themselves and their real situations. Through the discharge and follow up processes of individual case management, occupational therapy assists in confirming or adjusting people's medical

categorization and refers people, usually, to the psychiatrist who initially suggested admission, thereby perpetuating people's stigmatization and marginalization as psychiatric cases.

Besides the constraints produced by organizing practice around medical diagnostic categories and individual case management, another set of constraints contributes to the submersion of occupational therapy. Mental health practices are interconnected with the economic and welfare practices which control employment, housing, education and other functions in society. In these interconnections, economic and welfare practices constrain psychiatric cases from becoming contributing members of society. Philanthropic practices within housing, employment, recreation and state welfare confine occupational therapy to organizing special employment, social recreation and benefits which keep people on the economic margins of society. Occupational therapy is blocked from creating viable economic opportunities for and with people by a market ethic of expediency which perpetuates the stigmatization and marginalization of people diagnosed as psychiatric cases.

The fourth set of organizational constraints arises in the interconnections between mental health services, state legislated economic and welfare practices and professional legislation and codes of ethics. Provincial occupational therapy legislation generally defines occupational therapy as a practice which requires medical supervision so that practice tends to occur primarily in medically organized programs. As well, occupational therapy legislation and codes of ethics outline responsibilities for protecting people's safety but not for enabling the risk taking required for people to achieve their occupational potential or to become empowered.

9.4 Compromise and Resistance

9.4.1 'Fitting In'

The central tension between enabling people's empowerment and managing them as cases is inevitable in a modern society which needs to coordinate and control complex functions. The scale and complexity of institutions such as mental health services mean that the work of management is largely documentary, beyond the face-to-face organization of everyday situations. Therefore, it is documentary and other official practices, not overt discrimination or oppression, which result in some types of work being valued more highly than others.

This thesis has shown how occupational therapy is submerged by dominant institutional practices which favour the management of medical cases. Socially organized tensions, far more than lack of appreciation, poor public relations or professional conflicts, constrain occupational therapy's potential as an empowerment-oriented practice. The institutional submersion of occupational therapy occurs through documentary and objectified decision making processes. Institutional processes and practices, which are largely documentary, officially sanction the work of managing medical cases while rendering the work of enabling empowerment largely invisible, peripheral and irrelevant. Occupational therapy's submersion is both organized and displayed through practices such as categorization, accountability, decision making, definition of philosophy, budgeting, risk management, discharge and follow up (see analyses in Chapters 3 to 8). Although the majority of these processes are organized within the institution of mental health services, they interact with other institutional processes and practices in society. It seems that the organization of occupational therapy around medical diagnostic categories and individual case management is interconnected with philanthropic economic and welfare practices. These all interact to perpetuate the stigmatization and economic marginalization of psychiatric cases. In mental health services, institutional processes and practices officially recognize and support the

work of managing medical cases. There is no official commitment or organization to recognize and support the work of enabling empowerment.

It is important to note that the central tension identified in this analysis is not unique to occupational therapy. Other practices, particularly adult education, community development, health education, psychology and social work, display an interest in enabling empowerment (see Chapter 1.2). These too may face tensions in being organized by the institutional processes and practices which support the management of medical cases. However, the tensions of attempting to enable empowerment while managing medical cases seem to be compounded by occupational therapy's congruence with management. It seems that occupational therapy is not only submerged, in part, by management; it has become a form of management.

On the one hand, occupational therapy is organized by management in order to coordinate it with the work of other health professionals. Analyses in Chapters 3 to 8 provide a myriad of examples: job descriptions designate a particular portion of health professional work as 'occupational therapy' and specify how this work will be coordinated with that of psychiatrists and other professionals; the emphasis on practicing within facilities with face-to-face team coordination enhances the management of quality and efficiency in team work; and community practices are confined, in part, to coordinate occupational therapy with medicine more than community practices.

On the other hand, occupational therapy is also a form of management. Professional guidelines even describe practice as a management process with stages which include accepting referrals, assessment, planning, intervention, discharge, follow up and evaluation (Canadian Association of Occupational Therapists, 1991). By adopting a management process of practice, occupational therapy lays a management foundation which increases occupational therapy's congruence with institutional processes (particularly the documentary processes used to make

practice accountable). This management foundation presents a challenge if occupational therapy is to develop its potential as a transformative empowerment-oriented practice.

It appears that both the central tension and occupational therapy's work of enabling empowerment are submerged. As a form of management, occupational therapy has become so congruent with institutional management processes that the tension is not readily visible. The fit is such that occupational therapists remain largely unaware of the organizational source of tensions surrounding key features of practice. Occupational therapists certainly experience tensions. However, from a standpoint within everyday experience, tensions are experienced as being 'different', 'deficient', 'liberated', 'powerless', a 'go between', a 'keeper of confidentiality', in a 'different mind-set' and 'confined within hospital boundaries' (see Chapter 1.7). Only since the 1980's have the six core features identified in this thesis received any amount of critical analysis (see Sections 3 of Chapters 3 to 8).

Overall, it appears that occupational therapy remains unconscious of the socially organized tensions revealed in this thesis. Yet, through compromise and compliance, occupational therapy has contributed to these tensions by making practice congruence with medical case management. Therefore, occupational therapy is an active agent in its own submersion. In saying this, I am not blaming individual occupational therapists or the profession. Institutional processes and practices within and outside mental health services almost submerge occupational therapy. However, occupational therapists create at least some of the documentation required for the institutional management of medical cases. Without this participation, occupational therapy's submersion could not occur. Compliance, compromise and congruence with these institutional processes and practices reproduces occupational therapy's organization as a practice which primarily manages medical cases.

9.4.2 Celebrating Difference

Despite being organized primarily to manage medical cases, occupational therapy appears to resist this organization in what I have called glimpses of an ideal empowerment-oriented practice. However, these glimpses are hardly visible in the institutional management of occupational therapy. Even to the casual observer, glimpses appear serendipitous, little more than interesting twists which do not seem to disturb the management of mental health services. In these glimpses, occupational therapists appear to themselves and others merely to be out of step with the dominant practices used by other team members within programs and by mental health services overall¹.

And yet, in its identification of people's everyday life circumstances, its attention to the context of people's lives, and its support of collaboration, occupational therapy prompts people to challenge (albeit in small ways) the hierarchical authority of the medical processes which prevail in mental health services and the economic and welfare practices which dominate community life. In attending to people's real lives beyond program facilities and schedules, occupational therapy breaks away from managing medical cases and shifts into some aspects of the work of enabling empowerment.

To me, these glimpses are philosophically-grounded moments of actual resistance. After reading this thesis, some might conclude that occupational therapy is an 'allied' health profession which is actually an adjunct of medicine. I do not agree. In my view, occupational therapy is almost but not completely submerged. As well, I have used the metaphor of 'submersion' to portray a profession which has little visibility on the surface. However, there is more than meets the eye. Like an iceberg, the greater substance is invisible, hidden from easy view.

¹ This feeling of being different seems to have propelled occupational therapy throughout the ages and has given me considerable impetus to finally articulate my own sense of difference from the critical perspective of the thesis.

Occupational therapy survives and sustains its own work in small ways which poke above the surface as glimpses. These are not imaginary glimpses or idealized interpretations of practice. Glimpses describe actual practice and display openings for expanding features of occupational therapy which are consistent with an ideal empowerment-oriented practice.

Therefore, glimpses of possibilities for enabling empowerment seem to be significant and, at times, transformative points of resistance to the medical management of cases. Although the management of medical cases prevails, occupational therapy's empowerment-oriented beliefs and practices are sustained. Glimpses of an empowerment-oriented practice may appear serendipitous, but they spring from fundamental features which are generalizable across occupational therapy's mental health work. However, as they stand, glimpses retain occupational therapy's empowerment-oriented practice in the margins where it presents no significant challenge to mental health services or to state legislated economic and welfare practices. As yet, occupational therapy has presented no serious resistance to develop alternative processes and practices which might be more compatible with managing the work of enabling people's empowerment². Some occupational therapists may feel 'deficient', 'powerless' or 'confined within hospital boundaries' as medical case managers. However, others seem to exhibit pride in being 'different', 'liberated', a 'go between', a 'keeper of confidentiality', or in a 'different mind-set'. It is these positive experiences of pride which may provide occupational therapy with the impetus to enhance its work of enabling empowerment.

² A legitimate question is whether any form of modern management would be appropriate for enabling empowerment. Empowerment is grounded in lived reality: management operates through facts which have been extracted from lived reality. Furthermore, management uses selected facts in the institutional control of reality. The most optimistic view is that management organized around narrative documentation, or documentation which is most faithful to people's lived reality would be more compatible than documentation which organizes the management of medical cases.

9.4.3 'On Balance'

Glimpses of occupational therapists resisting the management of medical cases are important. However, on balance, these instances are not sufficiently prevalent or persuasive to change occupational therapists' potential for enabling the empowerment of people who attend transitional mental health programs. Occupational therapy's organization around medical categories and individual case management within program facilities are serious threats to this profession. Instead of developing its potential for enabling empowerment, occupational therapy's potential is submerged beneath medical, management, economic and welfare practices which organize this work to manage medical cases. The social organization of occupational therapy's mental health work overlooks occupational therapy's potential to enable empowerment and reduces it to the management of cases.

My concerns are not only those of professional self-interest. I believe that this submersion has broad social significance. Within the field of education, the analysis highlights the constraints for enabling empowerment unless disadvantaged or different types of learners are recognized as having active power to engage in the risk taking required to transform themselves and society. Without a social commitment to enabling the inclusiveness of diverse learners, critical pedagogy, democratic education and other liberatory educational practices face socially organized constraints. The submersion of occupational therapy's potential for enabling empowerment has broad social significance. The analysis here shows the types of socially organized constraints faced by all professional and non-professional practices, including those involved in social movements, where the aim is to enable people's empowerment. In submerging its potential, occupational therapy is perpetuating an individualized and managed approach to life, bereft of an ethical commitment to empowerment and social justice.

CHAPTER 10
REFLECTING
ON THE STUDY AND IMPLICATIONS FOR CHANGE

10.1 Introduction

This chapter completes the thesis. I use it, first, to reflect on my experience in conducting the study. Second, I summarize implications for practice, education and research.

10.2 Reflections on the Study

This has been a difficult study but one which has been totally absorbing and stimulating over the four years or so it has taken from the first entry telephone call to completion of the written analysis. The difficulty has been in finding a focus and structure for writing the analysis. When I first learned about institutional ethnography, it felt natural. Its investigation from a standpoint in the material world of everyday experience is exactly what I have been doing throughout my career as an occupational therapist. Even its concept that everyday experience is embedded in an 'environment' is a poorly articulated but fundamental concept in occupational therapy. Institutional ethnography, like occupational therapy, uses an interpretative framework to understand everyday life beyond its face-to-face, instrumental practice. Both analyze barriers which limit the development of marginalized social groups although occupational therapy's special emphasis is on barriers for people living with a disability while institutional ethnography developed to investigate women's inequality. Nevertheless, both institutional ethnography and occupational therapy rest on a vision that inequalities in society can be transformed.

However, familiarity with the fundamental concepts and processes of the method has not made institutional ethnography easy to write. One part of the difficulty is that institutional

ethnography generates a large, complex data base. Data are extensive since they are not streamlined into predetermined categories of interest. Instead, data collection starts in the complexity and disorder of everyday life. Therefore, observation notes are full of conversation and actions as mundane as occupational therapists speaking to people at water fountains about their bus fare to and from programs. It took a long time of reading, thinking and reflecting before I began to see how talking about buses at the water fountain displays interconnections between diverse work processes. In asking people about transportation, occupational therapists are displaying how everyday professional practice is connected to the institutional process of individual case management: professionals check progress on goals such as 'give one compliment per day to anyone' by documenting how the person was 'observed giving a compliment to another group member while they were both at the water fountain'. Another progress note related to the same goal might state that 'bus tickets arranged so that the person might have more interaction in public'. These progress note might be cross-referenced in individual health records to a list of assessed problems, such as 'feeling too anxious to interact with people in public places'. On reflection, I realized that these seemingly brief documentary notes of a problem, goal and progress are used to make occupational therapy's work accountable for individual case management. As well, after a while, I began to realize that giving out bus tickets provides a concrete example of a real, material practice in which occupational therapy's work intersects with the work of social welfare. Occupational therapists administer the face-to-face philanthropic work of providing special transportation allowances to people with 'special needs'.

The struggle to see these interconnected pieces of work seemed particularly drawn out since I learned the method from an introduction to it in Ann Manicom's graduate course on qualitative research methods. Further methodological inquiry has been done through reading Dorothy Smith's texts, from reading other institutional ethnographies, and from auditing

Marguerite Cassin's graduate course in which she teaches students to think about an institutional analysis of management. These were all helpful experiences but I had never actually completed even a small institutional ethnography on my own.

Although I developed the general argument for the thesis after a few months of analysis, I wrote many convoluted drafts over approximately two years to see if I had discovered how to put an institutional ethnography down on paper. None of the institutional ethnographies I read seemed to guide my way more than giving me a feel for the type of analysis required. Institutional ethnographies analyzing different processes in different types of work were actually distracting since my tendency was to apply to occupational therapy their analyses of gender or class relations in the practices of accountability, curriculum, or management. Therefore, I found that the development and clarification of each analytic idea required me to sustain ground breaking thought right up to submission of the thesis. Often, analysis challenged assumptions (including my own) about this profession.

After three submissions of major chunks of a thesis, committee questions prompted me to shift away from analyses of accountability and so on. I then began to analyze features considered to be central in the work of enabling empowerment. This meant creating a vision of an ideal practice as a conceptual framework for analyzing the work of enabling empowerment. Explication of this conceptual framework provided the backdrop for analyzing occupational therapy literature and practice. In reality, development of the conceptual framework occurred in tandem with development of the institutional analysis of practice. I selected features from those which are emphasized as central in literature on enabling empowerment. However, the selection included features which I analyzed as foundational in occupational therapy.

Once the focus shifted, the analytic work was arduous but exhilarating. Since I am an occupational therapist myself, the analysis was a process of bringing my professional work into

view as I had never seen it before. The difficulty over the final two years has been to separate analyses of various features into separate chapters. Each feature is so interconnected with the others that drafts of chapters looked like a mixture of the current six chapters repeated with variations. I knew what I was trying to say but my attempt to show all the permutations of interconnections made for dense, incomprehensible reading, as committee members will attest.

Another difficulty was to capture the glimpses of possibility as well as the constraints. Capturing the tensions on paper has been complicated since their presentation requires a certain balance. At times, drafts sounded idealistic and uncritical, with tensions receding into the background while the glimpses gained excessive prominence. At other times, drafts depicted occupational therapy as a colonized profession, since descriptions of constraints seemed to obliterate the glimpses. No doubt, finding the balance in writing about tensions has been made even more difficult since my own professional career is being exposed. Certainly I did not want to arrive at an analysis which showed that occupational therapy had no potential for enabling empowerment. That would have implied that I and my colleagues have been deluding ourselves and that the profession is nothing more than an adjunct to medicine.

The stimulating part of this study has been an opportunity to step back from the practice which has absorbed my professional career for over a quarter of a century. Doctoral work as a mature student has been exciting as a process of consciousness raising which has no doubt contributed to my own empowerment. As well, it has been stimulating to go into an actual practice situation and record what therapists are really doing. As an academic, I invite practitioners into the classroom and devise learning exercises which take students out of the classroom. However, I am not practising on the front line with people with disabilities. My educational practice of occupational therapy aims to provide students with the academic background to go into field situations with preceptors who know those situations. The

opportunity to observe and participate has enriched my current understanding of practice and possibilities for educating student occupational therapists.

Finally, the study has offered an analysis which, hopefully, will guide the way to practical change in the profession. The methodological grounding of institutional ethnography in the material practices of everyday life offers affirmation of occupational therapy which, too, is grounded in people's everyday lives. However, the study has pointed to the absence of critical analysis of the institutional organization of both practice and people's everyday lives. Nevertheless, I am optimistic about the potential for change. From my observation, occupational therapy seems to attract people who like to operate with a set of ideas which give meaning to the practical world and suggest a route for transforming that practical reality. My sense of hopefulness has been fanned by the interest which many occupational therapists have expressed about my analysis. Some occupational therapists will be uncomfortable with, and possibly resistant to, the analysis. But most of those with whom I have talked say that it is an accurate portrayal of their own experience. Pessimists may be discouraged in reading this analysis and may even use it to justify their shift into counselling, medicine or some other field. Hopefully the optimists will expand the glimpses of an important ideal. These are the people who might act on the following implications for practice, education and research.

10.3 Implications for Practice: Mapping a Route Towards the Vision

Practice constraints are unnerving to contemplate since they display occupational therapy not fulfilling its good intentions. Yet, critical analysis offers liberation by guiding the transformation of practice (Carr & Kemmis, 1986; Fay, 1987). The challenge is to visualize how to re-organize practice to reach more fully towards features consistent with enabling empowerment.

The following sections suggest changes which arise directly from this study's empirical analysis of occupational therapy's mental health work. Therefore, suggestions are not a product of my idealistic fantasy. Nor do they propose a new theoretical model of occupational therapy. Instead, they describe the actual activities required to change constraints which have been identified through this study of occupational therapy. Occupational therapists will recognize the ideas for change. In one form or other, they have been discussed for years. However, it seems to me that the profession has approached change primarily using a strategy of public relations and position statements. These are laudable activities. But they rely on convincing others to value occupational therapy. Public relations and position statements are indirect action because they leave others to translate ideas of occupational therapy's value into the policy, financial and legislative practices which govern occupational therapy. First, the approach assumes that occupational therapists are helpless to make these changes. Second, the approach rests on assumptions that occupational therapy is undervalued. To date, occupational therapy has had no empirical analysis on which to formulate a practical strategy for developing the profession's potential. Addressing 'value' locates ideas for change in theoretical notions.

In contrast, the analysis of this study provides a practical framework for developing change in the way occupational therapy works. The changes suggested here require occupational therapy to make a strategic shift. They suggest an action strategy, led from within the profession, directed at changing the practices which govern this profession. Public relations might be used, then, to highlight the public shortsightedness and submerging work which displays possibilities for enabling people to become empowered.

Implied in these suggestions is a call for occupational therapists to become empowered in order to empower others. Also implied is a call for occupational therapy to instigate new forms of professional practice, management and institutional practice in health, employment and

other fields. These new forms would coordinate and control multiple, intersecting practices so that power is shared rather than controlled by select groups such as professionals.

An overview of this challenge shows that occupational therapy's client-centred approach needs to develop into advocacy for political, economic and legal recognition of the power of all persons to act. Practice needs to incorporate explicit awareness of the interdependence of individual action and develop approaches which structure a profession and community conducive to people becoming empowered. Collaboration needs to extend into policy and legal decision making. Furthermore, the therapeutic use of occupations needs to be developed so that people are engaged in real occupations which develop empowerment in real life situations. Occupational therapy needs to develop theories of change which identify the risk taking required to transform experiences and conditions of powerlessness. Finally, occupational therapy's concept of spirituality needs to stretch beyond respect for individuals to the promotion of global inclusiveness consistent with social justice.

Before looking more carefully, it is important to emphasize that the development of practice has no finite end and requires continual checking. Of particular importance, development requires occupational therapy to be what I call community-minded. By being community-minded, I refer to the way both institution-based and community-based practices define their purpose. Occupational therapy needs to state explicitly how practice contributes to people's empowerment in the context of real community conditions. Change might be addressed in a gradual, incremental fashion which slowly moves the profession towards its own vision. However, I encourage the profession to be forward looking and courageous in instigating major changes in occupational therapy and society.

Suggestions are organized to address the three arenas of practice described in Chapter 9: conducting everyday practice; structuring specific programs; and organizing professional,

institutional and community conditions.

10.3.1 Conducting Everyday Practice

Since everyday practice consists of talk, action and documentation in material conditions, it is these three modes which are accessible to change within the daily practice of occupational therapy. To develop occupational therapy's person-centred potential in this arena, occupational therapists would refer to and document people's activities using 'active' designations such as 'people', 'clients', 'members', 'residents', 'workers' or 'citizens'. In enabling individual or social change, occupational therapists would discuss and document interconnections between people's mental difficulties, gender, race, class or other characteristics. Therapists would develop programs in which people with mental difficulties would be educated to act on common gender, race, class or other experiences. To develop an ideal practice, some occupational therapists would continue to work with individuals with difficulties. Other occupational therapists would develop 'social' practices with families, self-help groups, planning organizations, governments and so forth. Practice would be conducted with decision making partners throughout all stages of practice, including decisions concerning service access, assessment approaches, goals, intervention options, completion of services and evaluation.

A vital shift would be to re-discover occupational therapy's historic foundation in the occupations of people's real lives. This means bringing occupations back into the language, medium, process and documentary framework for all aspects of practice. People would select occupations which they deem relevant to and meaningful in their real lives. One emphasis of this educational practice would be on facilitating critical reflection through consciousness raising about people's experience of power or powerlessness in particular occupations. Occupational therapists would facilitate consciousness raising to help people examine how disability, age, gender, race,

class and other characteristics organize their experience of power as they engage in particular occupations. Another emphasis would be on making people's empowerment (and social justice) an explicit long term goal even when coaching people to develop specific problem solving, decision making and instrumental skills for everyday living.

A third emphasis would be on forming partnerships with individuals and groups to develop critical analyses of their occupational limitations and strategies for changing professional, institutional and community conditions which limit their empowerment. These partnerships would involve negotiation of responsibility for risk taking in engaging in real occupations. Positive risk taking would be defined as that required for people to be included as worthy citizens with entitlement to share the social and economic resources of society.

10.3.2 Structuring Specific Programs

A second arena is that of developing the space, time, philosophy and funding structure required for a person-centred practice which develops decision making partnerships with people and is grounded in people's real occupations. As staff therapists, occupational therapy managers, fieldwork coordinators, continuing professional education coordinators, researchers or other types of practitioners, occupational therapists would develop specific program philosophies, locations, time frames, budgets and educational processes which are congruent with occupational therapy's interests in enabling empowerment. Rather than complying with what exists and looking for underground methods of retaining occupational therapy within a given structure, occupational therapists would negotiate the incorporation of occupational therapy's interests in these documentary forms of management. In order to guide people through transitional barriers between medicine and real life, it would be important to retain some practice in hospitals and other institutions where real life can be simulated in a protected, practice environment. However,

the majority of practice would shift from simulated sites to real life sites such as industry, community centres, homes, and so on. The shift to structure practice in real life sites would make it possible to use everyday occupations to educate an expanded range of social groups including homemakers, retired people, disturbed adolescents, homeless people, and others. Occupational therapists would continue to work with people with medically-defined disabilities. But occupational therapists would develop occupation-based processes with the diversity of people who experience occupational limitations. The implication is that occupational therapists would develop the proposals, management processes and funding mechanisms to demonstrate existing and variations of practice which are generally unknown to the public.

Some occupation-based education would be structured to attend to difficulties with self care and leisure. Where these are the occupational areas of emphasis, practice locations, time frames, philosophy and funding would be structured for occupational therapists to work in people's homes, neighbourhoods, schools, recreation programs and so on. However, other types of occupation-based education would be structured to attend to difficulties with productivity. For this type of practice, therapists would develop public or private funding to create education, training, and employment opportunities which enable people to be contributors as well as recipients in society. Some occupational therapists might develop pilot projects which would demonstrate how 'the disabled (crippled, crazy)' can be economically productive citizens. Other therapists might become involved in changing state welfare, education, employment and other practices from being 'philanthropy-oriented' to 'empowerment-oriented'.

10.3.3 Organizing Professional, Institutional and Community Conditions

This third arena is where occupational therapy would focus its energy. Suggestions for this arena would change the ruling apparatus which governs how occupational therapy works. Occupational therapists acting here would begin by organizing occupational therapy's own professional 'house' to reflect the profession's own ideas. A key change would be to write new professional legislation. Legislation would declare the purpose of practice as enabling people to develop their potential for occupational achievement consistent with empowerment and social justice. Practices which do not engage clients in occupations would be defined as outside the recognized domain of the profession. A central change in most jurisdictions would be to open practice to referrals from persons including but not limited to physicians. People would be legislated as decision making partners in all processes of practice. Legislation would uphold professional liability and discipline for malpractice and negligence. But it would also describe documentary procedures which would enable professionals and people to legally share the responsibility and liability for risk taking.

Related would be the development of a new professional code of ethics. Consistent with enabling empowerment, occupational therapists would develop a code of ethics defining occupational therapy's belief in the worth of all 'persons', the embeddedness of persons' actions in social practices, and the equality of 'persons' as collaborators in all areas of decision making. The code would highlight the importance of risk taking and occupational therapy's ethical commitment to promote people's inclusion in all realms of society. Therefore, a new code of ethics would call for professional respect for the worth and autonomy of persons and for their engagement in practices which acknowledge their equality and entitlement to collaborate in controlling professional practice. The code would identify empowerment and social justice as the ethical underpinnings of occupational therapy practice.

In addition, occupational therapists would develop those models and frames of reference which conceptualize active people engaged in real life occupations in the environment/society. In all professional discourse¹, occupational therapists would refer to people, clients or other 'active' designations. In addition, practice would be described using the language of occupation. Person-centred, 'occupational' specialties attending to aspects of people's real lives would replace medically-defined specialties such as 'psychiatric occupational therapy'. Other specialties might focus on 'enabling social change' or 'coordinating individual change'.

Occupational therapists would also press to organize institutional conditions conducive to developing occupational therapy's potential. Possibly the most significant institutional change to advocate would be that people have access to occupational therapy if they have 'occupational' problems. People might have access to health services if their occupational problems have some biological basis even if they have no diagnosable medical problems. Since this change would stretch the work of health services beyond medical interests, occupational therapists might advocate that provincial and federal health services be joined with other human resources, such as those already amalgamated (leaving out 'Health') in Canada's new, federal restructuring of ministries. Occupational and medical interests would be coordinated and controlled as legitimate, equally important practices. Flowing from such a change, occupational therapists would press for policies, procedures and institutional legislation to refer publicly in all circumstances to active people except when they are being treated in a physician-patient or other treatment relationship². In this more inclusive organizational structure, occupational therapy consultants, managers,

¹ Professional discourse could include records, brochures, journals, texts, videotapes or any other documentary form (see Chapter 2).

² This suggestion avoids challenging the fundamental concept of a 'patient' in a medical or other treatment relationship. In describing implications of this thesis for occupational therapy, it is not my prerogative to suggest changes in medicine.

researchers and others in governing positions would develop mission statements, job descriptions, workload measures, health and social records, quality assurance and audit criteria, accreditation, and general management information systems consistent with enabling empowerment. As much as possible, these documentary processes would be used as a starting point to shift budget priorities and to create empowerment-oriented legislation. This means that documentary practices would be organized to recognize and/or account for people's active collaboration as decision making partners in individual and social action. Documents would incorporate the language of occupation with reference to engaging people in real occupations, enabling risk taking, and promoting social and economic inclusiveness. Where there is management of programs rather than professional specialties, occupational therapists might advocate for job descriptions, such as 'occupational coordinator' which identify their 'occupational' interests in simulated, transitional or real occupations. In organizing institutional change, occupational therapists would attend to problems of inequality related to gender, race or other characteristics which interact with people's mental difficulties. The challenge here would be to negotiate that occupational therapy forms of management be officially incorporated so that they organize those institutional processes which are relevant to occupational therapy. Certainly these changes are substantial and idealistic. However, this is the magnitude of change required to create institutional structures which support an empowerment-oriented practice.

Occupational therapists would also initiate change in exclusionary community conditions. It appears that communities view medical patients as a medical responsibility. Changing such perceptions would be part of changing actual community practices. Key here would be changing the actual community practices of people who communicate ideas through various media: television, radio, newspapers, popular magazines, films, and other art forms. Occupational therapists would coach media persons and artists or actively engage in the arts as occupational

therapists. The challenge would be to create images, stories and local experiences in which people with mental or other disabilities are economically as well as socially included in community life. The emphasis would be on illustrating how certain professional and institutional practices (including occupational therapy), rather than sheer will power or a supportive family, make such inclusion possible. Instead of generating compassion, publicity would be oriented to portraying the practical changes required in the ways communities work.

As well, occupational therapists would join with marginalized groups to advocate for funding and legislation to meet their needs through greater diversity in the types of employment, housing, transportation and other services of society. This might involve occupational therapists in public policy and legislation discussions about the mandate of health services versus social services, education, employment and other institutions. Occupational therapists might take the initiative, in business, housing, education, transportation and so on, to invite consumer groups to participate in decision making.

Furthermore, to develop the profession's potential for enabling empowerment, occupational therapy would form new alliances with professionals and non-professionals advocating for conditions which support an empowerment-oriented practice. Certainly, non-professional alliances would be formed with activist groups with an interest in reforming professional services: mental health consumers, women's groups and others. However, it would also be important to develop public alliances with adult education, community development, social work, health education and community psychology. This means de-emphasizing occupational therapy's historic connections with rehabilitation professions, particularly physiotherapy and speech pathology, unless they shift towards an empowerment-oriented practice. Rather than lobbying or responding to issues with these traditional partners, occupational therapy would ally itself with new partners to publicly demonstrate that the profession is broader than its

physical rehabilitation interests.

In changing community conditions, occupational therapists would work with 'clients' which are community agencies, governments and corporations. Furthermore, occupational therapists would engage in public debates about such fundamental social practices as individualism, philanthropy and capitalism. Some therapists might publicly challenge market place practices to incorporate more options for part-time, supportive and other 'non-traditional' employment. This would involve occupational therapists in challenging union practices where these limit such options. Challenges would go to industry, corporations, insurance companies and governments to develop economic policies which support a diversity of contributions as worthy and productive. Occupational therapists might become involved in developing legislation to orient professional, institutional, economic and welfare practices towards empowerment. In all these challenges, occupational therapy would officially recognize interconnections between mental difficulties, gender, race, class and other characteristics.

In essence, occupational therapy occupies a special niche in society which places the profession on the threshold with people who are in transition or have permanent limitations for being active in everyday life. The implications for enabling the empowerment of such people are substantial. Although attempts to produce structural change would face enormous resistance, suggestions are outlined to portray the magnitude of developing an empowerment-oriented practice.

10.4 Implications for Occupational Therapy Education

The implications of this study for occupational therapy education are related to the implications for practice. Since entry-level occupational therapy education prepares general practitioners rather than specialists, the suggestions for educating mental health practitioners are

generalized to the whole curriculum. Furthermore, suggestions for entry-level education are directed at either undergraduate or graduate education. Although current entry-level education is all at the undergraduate level, some discussions have occurred about the need to make entry-level education available at the graduate level³.

From my stance as an academic educator, I focus on producing change from within the academic curriculum. Of course students must also learn to practice in the real world. This is where students report learning as relevant and practical. Academic learning is often discounted as out of touch, idealistic, or 'unrealistic'. However, in occupational therapy, students need to learn how to develop features in an ideal practice free of the struggle against submersion official requirements for managing medical cases. Nevertheless, in this section, I link academic change to change in fieldwork education. In occupational therapy, preceptors are practicing therapists, not academic faculty. Using guidelines developed in collaboration with academic educators and academic fieldwork coordinators, preceptors design and evaluate student learning experiences available in their particular practice conditions. Therefore, changes in academic education can, ideally, be incorporated into fieldwork education by preceptors who incorporate new practice approaches into actual practice. Conversely, academic education is ideally inspired by preceptors who translate new practice realities into fieldwork education and then academic education.

In summary, there are two main implications for education: educating students to develop person-centred practice; and educating students to structure the professional, institutional and community conditions which legitimize their work with the occupations of everyday life.

³ The reasoning for such an option would be to attract mature students who would be highly suited for the profession but who would only be attracted if they could build on an already-completed undergraduate degree.

10.4.1 Entry-Level Education

Some of the practice suggestions could be immediately incorporated into existing academic courses and fieldwork experiences. This statement is not meant to underestimate the time, energy and creativity required to make adjustments. However, my point is that there are many ways in which the suggestions for practice might be incorporated within the present structure of occupational therapy education.

For instance, academic educators might require students to refer to clients rather than patients or cases. Students might be required to attend to the environment as well as individuals in assignments. Most occupational therapy programs have courses or sections on community practice which could emphasize opportunities for working with people's real occupations and for engaging in social action. To increase students' awareness of equalizing collaborative decision making, educators might organize debates, analytic exercises or role plays in which students would identify hierarchical versus horizontal relations. Assessment and intervention courses might require students to incorporate real occupations into their ideas for working with people. To heighten student awareness of the necessity of risk taking, assignments might be developed in which students draft new forms of legislation in which risk and liability are shared by managers, therapists and people themselves. Educators might also organize learning experiences which require students to work with community support groups, housing cooperatives and employment projects which are attempting to include people with disabilities. To enhance consciousness of the social organization of community practices, courses might aim to promote 'critical analysis' or 'critical reflection' on social, economic, political, financial and legal practices throughout all aspects of community life. Possibly, students would learn to do the type of 'institutional' analysis used in institutional ethnography.

In fieldwork education, preceptors might also insist that students refer to 'clients', attend

to people's environments, collaborate in decision making, engage people in real occupations, enable risk taking in real communities and promote inclusive, community-oriented activities. Fieldwork education, of course, poses different challenges than academic education. The 'field' consists of the type of everyday practice analyzed in this thesis. Chapters 3 to 8 show dominant practices which will present the same challenges for changing fieldwork education as they pose for changing practice itself. It is fieldwork where students learn how to practice in real environments in contrast to the simulated learning organized within academic curricula. With a little reflection on Chapter 6, *Simulating Real Life*, one can believe that fieldwork education is far more powerful in shaping practice than academic education. The academic courses guide students to reflect on and become conscious of the philosophic underpinnings of occupational therapy practice, in other words, to envision and engage in an ideal practice. Whereas, in fieldwork students are confronted with the real situations and risk taking required to implement this philosophy in practice.

However, more substantial changes involve re-structuring occupational therapy education. Re-structuring means re-aligning occupational therapy's partners in the academic world. To develop a collaborative rather than submerged relation with medicine, occupational therapy would move out of Faculties of Medicine. Alliances would be formed with other health and social professionals⁴. Given its interests in everyday life, however, occupational therapy would benefit from organizational arrangements with adult, special and other types of education. Other relevant interconnections might be developed with anthropology, archaeology, economics, health law,

⁴ For instance, from an occupational therapy perspective, Dalhousie University offers a positive combination of professional programs. The Faculty of Health Professions includes seven health and social professional schools and one college (Pharmacy). Medicine operates out of its own Faculty. Some people in and outside this university advocate that Medicine be included in a Faculty of Health Professions since it, too, is a health profession. However, I believe that the Faculty of Health Professions, as it currently exists, is an affirmative structure which gives other health professions breathing space to develop out of the shadow of Medicine.

history, philosophy, psychology, public administration, sociology and other fields.

Re-structured curricula might educate students to structure and conduct a person-centred practice. For instance, interviewing courses would be based on an ethical commitment to recognize people as active worthy persons with rights to self determination and autonomy. Interviewing courses would challenge students to use a collaborative style of interviewing in which interpersonal, everyday decisions are a product of mutual decision making. Rather than describing these courses as generic 'interviewing' courses, they might be called 'partnership' or 'collaborative' interviewing courses. These courses would attend to professional power relations. As well, courses on groups would orient students to group dynamics and methods of facilitating both individual and social action. Here, education might ensure that students learn how to participate as professionals in social movements or how to facilitate collective action around social issues. Professors would attempt to model collaborative teaching methods so that students experience the kind of partnership which they hope to build with people in practice. In addition, students would learn how to include people in determining the structure and organization of occupational therapy and other programs. Discussions about funding, policies and legislation related to occupational therapy would incorporate exercises which include people in this type of planning. In educating students to be person-centred, curricula would demonstrate sensitivity to gender, race, class and other characteristics which intersect with ability/disability in shaping people's occupational potential.

Occupational therapy would also re-structure its curricula around the 'language and practice of occupation'. For instance, occupational therapy's specific interest is in the development of humans as occupational beings. Courses might be called 'occupational development' and draw on the emerging research from occupational science about the development of humans' occupational existence. Courses on assessment might be re-focused on

'occupational assessment'. The course content would be organized around categories of occupational performance and the environment. Rather than learning how to fit assessment information into medical diagnostic categories, students would learn how to use qualitative and quantitative assessment methods to describe how people organize their everyday occupations and to learn about the physical, cultural, social, economic, political, legal and other contextual features which shape their lives. Furthermore, students would learn how to develop occupation-based social action to change community ideas, funding, policies and legislation.

10.4.2 Graduate Education (Beyond Entry to the Profession)

Although the majority of occupational therapy education continues to occur at the undergraduate level, graduate programs are developing around the world. While many occupational therapists have developed specialties through continuing education and experience, there is a need for formal recognition of expertise, particularly in mental health services.

Of great importance to occupational therapy, graduate education offers a route for developing occupational therapy's empowerment-oriented knowledge and practice. At least seven universities in Canada are developing graduate programs at the Masters Degree level. However, these tend to be combined with physiotherapy in Masters of Rehabilitation degrees. Here, occupational therapy seems to be taking a retrograde step in re-aligning itself with physiotherapy after struggling throughout the 1960's and 1970's for separation at the undergraduate level (see Chapter 1). For some occupational therapists whose interests are in physical dysfunction, the alliance may be appropriate. However, since physiotherapy is organized around medical diagnostic categories, these programs tend to perpetuate occupational therapy's organization around medical discourse.

Instead, mental health practice which aims to enable empowerment needs graduate

education focused on the features identified in this thesis. Graduate education might raise critical analysis around processes such as categorization, documentary practices of accountability, decision making, program planning and evaluation, transformative change and community development. To specialize in mental health practice, graduate education would include critical analysis and practice approaches using person-centred, occupation-based education grounded in people's real life experiences. Graduate education would also emphasize policy making, consultation, lobbying, advocacy, social activism and legislative action. Such an approach suggests that graduate education for mental health practice would benefit from connections with graduate programs in management, education, political science or law⁵.

10.4.3 Recruitment

Student occupational therapists are the new ambassadors of occupational therapy. They hold the profession's potential in their hands because they bridge the academic and practical worlds of occupational therapy. They also hold the profession's future since they are speakers and actors who will develop future possibilities for occupational therapy.

Therefore, to develop undergraduate and graduate curricula to educate students in an empowerment-oriented practice, occupational therapy would increase its emphasis on accepting only those students who have demonstrated the ability to take leadership within society. Recruitment would be particularly focused on students who have demonstrated that they are not only academically capable but socially conscious and committed to developing an empowerment-oriented practice. It seems necessary to take some affirmative action on attracting students who are committed to enabling empowerment since past recruitment has tended to identify

⁵ Since many occupational therapists in Atlantic Canada live in places distant from universities, new forms of graduate education might be developed with distance, self-directed and other independent study options.

occupational as a rehabilitation profession linked with medicine. This means developing recruitment materials which present a visual image of the profession engaged in social action as well as individual forms of practice. Materials would depict an empowerment-oriented practice in schools, employment settings, outdoors, in homes and other settings as well as health institutions.

10.4.4 Professional Continuing Education

The implications of this study for professional continuing education are serious. The seriousness lies in re-educating people who have already learned how to submerge the ideal vision of empowerment in occupational therapy practice. Therefore, the real challenge is to develop the types of professional continuing education which enable practitioners to change. Some practitioners will welcome education which lays out a practical route for changing the tensions which they have experienced. Others will theoretically accept this analysis but will resist change. This dualistic depiction of occupational therapists accepting and resisting change is not meant to judge personal characteristics. It recognizes that some therapists will be inclined to change and will be in situations where change is supported in their personal and professional lives. Other therapists will be inclined to resist change, possibly as a personal reaction, but also because personal and professional conditions create barriers to change. For instance, many female occupational therapists may be unable, for marital, parental, financial or other reasons, to leave secure, salaried hospital employment for the uncertain, entrepreneurial activities described above.

Nevertheless, professional continuing education faces the difficulty of guiding professionals to become more empowerment-oriented. If one looks in any occupational therapy journal, the usual professional continuing education tends to be technical: courses on assessment techniques, intervention methods, new systems of workload documentation, or working with new

materials. As well, most events are medically-defined: advanced practice courses on working with 'schizophrenics', courses on 'psychiatric' case management, or workshops on 'depression'. This thesis points to a different type of professional continuing education to support a shift towards a more empowerment-oriented practice. For instance, there might be courses to learn institutional ethnography as a framework for developing activism. Or courses might involve strategic planning to address constraints imposed by medical categorization, accountability for efficiency, and so on as identified in the thesis. Fundamental courses might be offered to explore occupational therapy's fundamental beliefs since occupational therapists who completed their education before the 1980's learned far more about medical conditions than occupational therapy theory. A strong emphasis would be placed on education which develops critiques and alternate forms of management consistent with enabling empowerment. Furthermore, community development, activism and social action would be highlighted as necessary theoretical and practical knowledge for developing occupational therapy's empowerment-oriented practice.

10.5 Implications for Occupational Therapy Research

This study has presented a critical analysis of possibilities and constraints for developing occupational therapy's mental health work. It is only a beginning. With only 32 Doctoral Degree and 301 Masters Degree level occupational therapists in Canada, occupational therapy has actually conducted very little research (Canadian Association of Occupational Therapists, 1993b). Of particular concern to me, occupational therapy literature reports very little critical analysis of practice. While some empirical and phenomenological research is offering important insights for occupational therapy, my recommendations here emphasize the need for research grounded in critical social science. From this stance, I see four major research areas in need of exploration: gender, variations related to practice in other areas of health services, institutional systems other

than health services, and 'new paradigm' practice designs including implementation and evaluation.

Gender research growing out of this thesis might investigate the gendered nature of occupational therapy's mental health work historically and today. It seems that this work became feminized as psychiatric asylums became part of modern hospital systems around the time of the First World War (see Chapter 1). These are speculative ideas. Questions could explore links between feminization and the need for empowerment in occupational therapy's mental health work. Research might look at gender as an organizing feature in developing practice based in the real housing, employment and other occupations of people's lives. Or gender might be a question in investigating the social organization of 'productive' (waged) versus 'non-productive' (unwaged) occupations for people diagnosed with mental disorders.

Another area of research might look at practice in other mental or general health services. For instance, researchers might seek out the few occupational therapists who have developed practice in community mental health services to examine how (or if) practice attends to people's real occupations. Or questions might focus more specifically on analyzing documents such as mental health policy and procedures, record keeping, workload measurement, management information systems and total quality management. In mental health and other areas of health services, studies might look at the diverse 'occupational' difficulties of people with different age, culture, race, sexual orientation or other characteristics. Where researchers are interested in particular mental phenomena, such as pain or cognition, they might design studies which incorporate data on everyday occupations and people's historical and current life context.

The thesis has defined occupational therapy's relation with medicine, health services management and to some economic and welfare practices which intersect with mental health services. However, occupational therapists are also employed in schools, work places,

penitentiaries, social welfare and other systems. In those settings, occupational therapy is often viewed as the profession which can interpret medical problems in everyday life situations. In other words, occupational therapy continues to be defined by medicine even outside the health system. Research might examine how occupational therapy's mental health work is organized in non-health systems. Questions could look at occupational therapy features and the potential for developing occupational therapy's mental health work in various institutional practices from education to telecommunications. For instance, research might investigate occupational therapy's relation with social services which seems to be dominated by ideas of philanthropy rather than empowerment. Or research might analyze the relation between occupational therapy's mental health work and various practices in industry, corporations, unemployment insurance, workers' compensation, disability insurance agencies and so on.

An important area would be evaluation research. If occupational therapy's mental health work is to survive in hard economic times, there is an urgent need to articulate why occupational therapy should be funded within mental health or any other system. Therefore, researchers might bring empirical, naturalistic and critical analyses to evaluate the 'processes' and 'outcomes' of occupational therapy's mental health work. Institutional ethnography might be used to gather empirical data and to analyze how the occupational therapy 'process' or possible 'outcomes' are actually organized. Occupational therapy needs to evaluate pilot projects, trial programs, and other experimental ideas which experiment with developing an empowerment-oriented practice. Research might even develop criteria for determining 'cost-effectiveness' in enabling empowerment.

10.6 Final Comments

Teaching and learning for democratic citizen empowerment will require resolute adults who are in the struggle for the duration; furthermore, it must be realized that they must develop strength superior to the awesome power of capital and capitalist hegemony. This is not a job just for school kids and a few brave educators. (Brosio, 1990, p.81)

Brosio could be speaking to occupational therapy. Occupational therapy is an educational practice which works for the "democratic citizen empowerment" of people with occupational limitations. For occupational therapy, the development of democratic citizen education, which I equate generally with the work of enabling empowerment, requires nothing less than the transformation of health and other institutional practices.

Occupational therapy has a long way to develop its potential for enabling empowerment. The shift from managing medical cases to enabling empowerment is huge. Resolution of the central tension revealed through this thesis requires a shift from hierarchical processes of control to horizontal processes of partnership in mental health services and the economic and welfare practices of society. However, I believe that such a shift can happen a little at a time. Some may view this optimism as overly idealistic and romantic. Possibly. That is who I am. While I am committed to raising critical perspectives, I am also committed to taking an optimistic approach to life. Pessimism does not suit my character. I have shown that glimpses of the work of enabling empowerment actually exist in occupational therapy's mental health work. While some may wish to debate the magnitude of these glimpses, they do exist. Therefore, it seems important to develop these glimpses to enhance the educational potential in occupational therapy's mental health work for enabling empowerment.

APPENDIX A

COMPUTER CODING: ETHNOGRAPH

The coding of work processes was done by converting the 144 transcripts (approximately 5000 typed pages) of observations and interviews for use with ETHNOGRAPH, a microcomputer software package. The package converts IBM word processed files by numbering each line. It also provides a system for coding and sorting any size section from 1 line to a full document with searches of up to 80 files at a time. Codes for ETHNOGRAPH are applied by marking code sections on transcripts with numbered lines. Code names and line numbers are entered through a programmed menu. Seven layers of coinciding or overlapping codes can be used. Codes are changeable at any time. Coded sections can be reprinted with automatic inclusion of identifier codes inserted at the beginning and through formatting sections of the word processed transcriptions. In ETHNOGRAPH, I found an electronic coding system capable of physically dividing a large data base into multiple categories. The system was sufficiently flexible to divide overlapping or similar data chunks into many different categories. While multiple codes can be used and changed as the analysis proceeds, a large data base takes time to recode and to reprint coded sections. Therefore, considerable time was spent first in developing the categories for coding work processes (APPENDIX C), and later in developing the six analytic categories which became Chapters 3 to 8 of the thesis. Refined sorting of coded segments was organized manually.

APPENDIX A (CON'T)

COMPUTER CODING: ETHNOGRAPH

DATA CODES:

SITES, OBSERVATIONS, INTERVIEWS, CODE NAMES

Data referencing in this thesis uses one of the following segment identifiers followed by the line numbers in which the segment appears. Identifiers are:

SITES	OBSERVATIONS	OT INTERVIEWS	OT CODE NAME
B	BOB01 - 04	BINTOT01 - 04	Bev
C	COB01 - 02	CINTOT01 - 02	Carol
J	JOB01 - 03	JINTOT01	Jill
M		MINTOT01	May
N	NOB01 - 05	NINTOT01 - 03	Nora
P	POB01 - 30	PINTOT01 - 08	Pat
R	ROB01 - 30	RINTOTO1 - 10	Rita
(7)	(74 files)	(30 files)	

OTHER INTERVIEWS BY SITE

B	BINTAD BINTOTA BINTPC	ADMINISTRATOR OCCUPATIONAL THERAPY ASSISTANT PSYCHIATRIST
C	CINTPC CINTOTA CINTNS1,2	PSYCHIATRIST OCCUPATIONAL THERAPY ASSISTANT NURSE
J	JINTAD	ADMINISTRATOR
N	NINTCO NINTPC	COORDINATOR PSYCHIATRIST

APPENDIX A (CON'T)

COMPUTER CODING: ETHNOGRAPH

DATA CODES

SITES, OBSERVATIONS, INTERVIEWS, CODE NAMES

OTHER INTERVIEWS BY SITE (CON'T)

P	PINTEX PINTCO PINTNS1,2 PINTMT PINTPC1,2 PINTPY1,2 PINTSE PINTMH PINTCL1,2	ADMINISTRATOR COORDINATOR NURSE MUSIC THERAPIST PSYCHIATRISTS (2 PEOPLE) PSYCHOLOGIST SECRETARY COMMUNITY GROUP HOME ORGANIZER STAFF MEMBER, NEARBY MENTAL HEALTH CLINIC
R	RINTAD RINTPC RINTOTD RINTNS RINTREC RINTSW1,2 RINTVOC	ADMINISTRATOR PSYCHIATRIST OCCUPATIONAL THERAPY DIRECTOR NURSE RECREATION COORDINATOR SOCIAL WORKERS (2 PEOPLE) VOCATIONAL ASSESSMENT THERAPIST
(6)	(30)	

TEAM MEETINGS BY SITE

P	TEAM MEETINGS (8) TEAM RESPONSE TO EARLY ANALYSIS
R	ROUNDS (8) TEAM MEETINGS (8)

APPENDIX B

OCCUPATIONAL THERAPY'S WORK PROCESSES IN DAY PROGRAMS: NOTES ON DEVELOPING CODES FOR THE SECOND ANALYTIC PROCESS OF INSTITUTIONAL ETHNOGRAPHY

July 1990: Revisions #1 and #2

This list was generated in July 1990 from ACTIONS6.LST, SITE #6, with attention to stripping down any ACTION6 categories which appeared to be interpretive. After a first rough list from starting to read POB files, revision #2 (July 1990) now includes an attempt to separate action from topics, and to identify the people involved. I am attempting to describe only material actions - in the most basic sense, they include: act, talk, phone, read, write.

August 1990: Revisions #3, #4, #5, and #6

Revision #3 developed during coding of POB files (30 files). Coding started using code revision #2 but was soon organized to code the basic 4 actions followed by a suffix codes and subcodes identifying the person(s) involved, "WHO", the location of the work processes, "WHERE", and the actual description of the processes, "WHAT".

Revision #4 developed as coding proceeded with ROB files (SITE #2). The main change is that the "ACT" codes now encompass most "TALK" descriptions as well. Few codes are restricted to "TALK" alone. The codes "HOUS", "LEIS", "PROD" are used to categorize action

and talk about different aspects of life - using language which is constructed with reference to the performance categories of the occupational therapy Model of Occupational Performance, but which appears to sufficiently describe actual everyday activities as they occur. The categories do not interpret what might be "meaningful" or "purposeful" since "meaning" may be constructed by individuals in complex ways unattached to specific activities.

Revision #5 resulted from a realization that some "ACT" codes (e.g., MEDS, CASE) referred to topics not actions. The use of topics was hiding actions such as checking tasks, making notes during talk, and other processes such as those listed in the EARLY CONCEPTUALIZATION (Mar 23/90) outline. Categories such as facilitating, advocating, mentoring were avoided in this revision as they are interpretations of sequences and intersections of multiple actions.

Revision #6 occurred after meeting with A. Manicom. After reviewing the development and nature of codes, she suggested that the ACT, TALK, PHONE, READ, WRITE codes were useful in developing my thinking re occupational therapy action, but that they were all really forms of action. Since action is usually integrated with TALK, it seems unnatural to separate the 2. Also, much of the nature of professional work such as occupational therapy is TALK despite occupational therapy's bodily actions such as the use of physical materials, arrangement of space, physical demonstration, task participation, etc. The "WHO" and "WHERE" codes appear useful as is. The "ACT" & "TALK" codes should be amalgamated for the reason stated. They may become more refined as I continue to read and think about the observations, interviews, etc. The discussion led to thinking that the TOPIC codes are the most appropriate categories to select to examine how work is organized. The "TOPIC" codes need refinement to arrive at generic categories stripped of the professional discourse which glosses what is really happening. For instance, "PLAN" might reveal how people make decisions about what to do.

September 1990: Revision #7

Revision #7 was made after finishing the first reading of all POB files for 6 sites (no observations were made in site #7). In this revision, the topic codes have taken priority as a way of addressing the "pieces" (chunks, components) of occupational therapy work. This is level #1 coding. A 2nd level of coding within each piece developed with codes for "WHO", "WHERE", "HOW" AND "WHY". "HOW" included all the codes of educational and other actions which occur within each type/piece of work (e.g., ADL work will likely include "GUIDE", "ENCO", "SCHED", etc.). The "WHY" codes will be the explanations of why actions occur as they do, why each "piece" of occupational therapy work is organized the way it is (THIS WILL BEGIN EXPLICATION OF THE SOCIAL ORGANIZATION OF EACH PIECE OF WORK). The observation notes include some "WHY" explanations where I was able to ask questions as action proceeded. The majority of the "WHY" explanations are in the interview data which I have not yet read since transcription. My memory of the interview data is that it too would produce the CODELIST currently being developed. Some adjustments may arise as I actually read the interviews later.

October 1990: Revisions #8 and #9

Revision #8 is a grouping into 7 categories of work processes. Ann's comment on looking at it as we talked was that the groupings were useful to see types of processes but they lacked the conceptual framework for an institutional ethnographic analysis. The clustering needs to open possibilities for analysis of the ways that intersecting processes, discourse and documentation shape the work to dominant practices and discourse. In particular, the "WHAT", "WHERE", etc., coding can not really be separated because the explication of everyday work to institutional processes requires integration of this information to see how the work is organized.

After the meeting with Ann, I read the occupational therapy interview transcripts thinking particularly about the work intersecting with that of others, and about the sufficiency of the existing codes to cover occupational therapy work. The categories appear to hold. I did not discover work processes which had not been seen or discussed in observation notes. However, I found myself stuck with a large area of connections with other professional, management and "community" practices. The community connections include the work to gather information on community services and resources. It also includes work to fit clients into those resources which the client defines and/or the therapist suggests would facilitate goal attainment, support, monitoring and so on. In many instances, this is connecting work between health institutional and non-health institutional processes. However, as I think now, some of this community work is shaped to serve dominant notions of appropriate housing for people with mental disabilities. For instance, where the occupational therapy is assessing whether people fit the criteria, and whether they are prepared for and supported in their actual efforts at group home living, occupational therapy work is shaped to support dominant social notions of helping (offering people low-cost space in a state-operated group home with others not of your own choosing). Starting from a framework of dominant work and talking about occupational therapy connections turns out to be backwards and without explication of how the work is organized to serve (provide information, prepare for, etc.) or extend (reinforce, pick up on) the work of others.

Revision #9 is a new attempt at clustering. Although the clustering seems to be an organizational pre-occupation, I have such a large data base that I need a basis for sorting out some sections which I can read and think about in detail. I can't pick sections without a basis for deciding what to include and exclude. Production of the health promotion methodology paper for presentation has helped my thinking of the current 8 cluster categories.

I returned to reading observation notes while referring to revision #9 and developing

revision #10. I began to follow up on the idea from Ann to start with goals. This thought brought me to focus on client work as the core and *raison d'être* of occupational therapy work. That meant that other occupational therapy work is actually participation in the organization of client work. Occupational therapists' involvement in developing the program and resources (in the program and beyond the program in the community) is actually structuring/producing the conditions on one side of client work. On the other side of client work is accounting work - to account for the work with the client as well as time accounting for the production of the program and resource conditions. I thought that I needed to talk first about client work as a whole and not just assume that the focus was goal setting. I think that's a major element but I shouldn't jump ahead of my data. After these coding deliberations, I began to write about client work. It was very difficult and I kept finding that I needed to say so many things before I could talk about client work. So I have produced my first 11 page attempt at writing the thesis. It begins with clarifying terms used to generalize to protect anonymity. I now find that I need to give the reader a snapshot view of space and time. Other wise I am continually trying to describe bits of the setting and program structure to explain organization. Yet, the reader would have no sense of that space and time ground the work as if fixed, even though space and time both flex to accommodate the work. Finally, I need to say where I am going in an introduction to client work. So I have decided that there are particularly points which I want to set out as my arguments. In essence, I am arguing that space and time limit liberatory action with clients and that efficient management isn't the answer. So, there is an argument about working to management relevances - space, time, efficiency. Next, I find myself arguing that the hospital links produce an ideological squeeze between medical/management and community development/liberatory ideologies. There are more arguments about working to management relevances and some for working to dominant/ruling professional relevances (particularly

psychiatry, to some extent psychology). I am now left with client work as a huge topic piece/category. How to divide it up for discussion? Options for dividing: 1. areas of daily living - self care, work/volunteering, leisure, housing, 2. working with goals: identifying needs, planning (goals, etc.), implementation (doing/action), 3. individual or group/collective, 4. interests in competence/skill, daily management (habits, scheduling), psychological, medical/biological, social relations/integration/networks/social linking, financial, legal, spiritual, service brokering (referral linking)

January 1991: Revision #11

Revision #11 was completed in January, 1991 after a period of developing the thesis argument and beginning to flesh out the points for each chapter. After identifying a chapter content (from reviewing Ann's thesis for organizational/argument building ideas) I read Smith again (power) and Stanley. As I read, I began to fill in points as they seemed to fit - as orientation, as theory, as analytic points associated with the data (which will be analyzed in ch 5, 6, 7, 8). After 72 pages of point form, I divided the file into chapter files and feel the beginning of an actual thesis. I have returned to the data to re-order, and possibly re-categorize, the coding scheme. I want to see if the categories are big or small enough to contain the action/discourse which I want to raise in the analytic scheme developing for the thesis. I realize that major code headings were essentially the chapter headings. The codes are a data-based, point form version of the analytic chapters of the thesis. Now, I am actually testing the analytic systems with the data and the data with the analytic systems. I am reading the data backwards (sites 6 to 1) to test the lack of fit as well as fit with the emerging analytic scheme.

March 1991: Revision #12

Revision #12 is becoming the topic definitions of the thesis itself. As I work through the point form of the thesis and see the logic of drawing particular topics into the argument of particular chapters, I am shifting topic areas so that the code list and chapter divisions are the same. For instance, I initially saw job descriptions as "Situating Occupational Therapy Work". However, in completing a class assignment in a course I am auditing (Dr. Marguerite Cassin's Public Sector Management), I analyzed the social organizational processes of the job descriptions of therapists in this study. In this exercise, I began to see the job description more as labour control, like workload management, etc. The description, an explicit categorization of the division of labour, is constructed to control who will do what, and therefore, who can expect pay for what duties. The elements in as well as outside the description provide the basis for job analysis and pay scales. Also, I now see that policies re client rights are not merely situating work (order/disorder), but are the work to be described. What "client rights" work do occupational therapists' attend to? And how is this work socially organized?

It was also during these deliberations that I began to clear out my definition of social organization as: the visible and invisible connections which tie what appear to be discrete, unconnected actions into generalizing courses of action, i.e., a general set of social relations.

I am finally getting to a point where I have sufficient confidence in my coding to do another read through, attach codes and section the data for closer analysis for particular points and chapters. The coding has served as a "trial" thesis analysis without writing each version out in a full thesis. The codes provided a map of my developing framework of thinking.

**TOPIC AREAS OR "PIECES" OF OCCUPATIONAL THERAPY WORK
MARCH 14, 1991
CODE REVISION #12**

**SITUATING OCCUPATIONAL THERAPY WORK: DEFINING ORDER AND DISORDER
(PROFESSIONAL IDEOLOGICAL STRUCTURING PROCESSES)**

**(A) SPACE NOT SPECIFIC TO INDIVIDUAL CLIENTS (ORDERING THE PHYSICAL
WORLD OF PROGRAM FACILITIES, EQUIPMENT, LOCATION)**

INVEN - materials, supplies, food, equipment, facilities: includes writing or checking purchase orders, arranging storage space, recording or checking inventory, positioning items in space, decorating facilities, observing/checking (supervising) others in inventory tasks, fixing broken or faulty equipment, materials EXCLUDING "SITE"

SITE - physical work conditions as a condition for working with clients, such as layout, rooms, location in institution, surroundings, location of particular work inside and outside the facility, home visiting, community visiting, access such as keys, juxtapositions, air, light, temperature EXCLUDING "INVEN"

**(B) TIME NOT SPECIFIC TO INDIVIDUAL CLIENTS (ORGANIZING THE TEMPORAL
WORLD AS A PROGRAM FRAMEWORK)**

STRU - time structure of the program, daily, weekly, monthly, yearly sequences or events considered as the "program", time patterns, theoretically agreed uses of time (implicit, explicit) for both clients and staff

(C) TEXT: NOT SPECIFIC TO OCCUPATIONAL THERAPY

PROGR - program philosophy, purpose, goals, content areas, team philosophy and dynamics, interaction, attitudes, values, beliefs, emotions, personal issues of others not the occupational therapist, individual contributions of staff to the program, "self-disclosure" by staff, theoretical orientations to choice of program activities, professional theoretical orientation, stated philosophical basis for determining the scheduled use of resource conditions (resource people, inventory, safety conditions, space and time), normalization concepts, implicit and explicit philosophical orientations of staff members

SERV - organization of program versus client links between the program and professional, formal, organized service people outside the team and which formalize the extension of the reach of the team's services or extends team-like services beyond the program, groups, agencies who provide services to/with people who are clients in the day program

SUPP - non-service, non-professional, informal resource people including family, friends, self-help groups, and their links with the program, their availability for clients, access, types of services EXCLUDING WORK RE HOUSING, ETC.0

- (C) TEXT: SPECIFIC TO OCCUPATIONAL THERAPY PROFESSIONALIZATION DEVELOPMENT WORK**
- CE** - occupational therapists' ongoing/continuing education/learning - formal & informally structured actions
- PERS** - occupational therapists' personal matters categorized as personal actions which are inserted into work (e.g., bringing in recipes for cooking groups)
- PROF** - professional/ization matters, appearance - dress, hygiene, grooming, mannerisms, facial expression, professional qualifications, symbols/activities directly associated with professional status
- STUD** - student matters with occupational therapy or other students who are being oriented to occupational therapy work; student work may also be non-specific to occupational therapy if occupational therapy or other students are being oriented to the program rather than to occupational therapy)
- INOT** - information, pamphlets, about occupational therapy services, approach, purpose, theory, ot interests

CLIENT WORK:

ATTENDING TO INDIVIDUAL DEFICITS IN AN "ENVIRONMENT" VIEWED AS BACKGROUND OCCUPATIONAL THERAPY WORK WITH/ON BEHALF OF IDENTIFIED CLIENTS; AND INTERSECTING WITH OTHER PROFESSIONAL (CH 5) AND MANAGERIAL PROCESSES (CH 7)

(A) WORK PROCESSES

- BODY** - attending to client's bodily parts, bodily functions, bodily actions considered as an entity
- DIAG** - diagnostic interests such as talk and/or action associated with sets of behaviours and bodily functions which have been medically/psychiatrically classified as diagnostic categories
- ENTRY** - working with clients entering the service - processes, decisions, purpose, goals, plans, actions, resources, program, etc.
- FIN** - financial dealings re costs for clients for participation in the program and beyond in their lives
- HABIT** - attending to client's organization of time, space, text (habits and roles): work with clients organizing schedules, routines, guidelines, structure of everyday activities into daily, weekly, monthly or other patterns (**PARTICULARLY INTERSECTING WITH STRUC**)

ISSUE	- attending to social issues such as environmental protection, recycling, AIDS, daily news
LEGAL	- attending to legal policies, regulations, limitations, supports associated with client everyday life or occupational therapy work with clients
LINK	- processes of preparation of information on programs, agencies, services, people, connecting or brokering specific links with or on behalf of clients between the day program and other services, referrals, accompanying clients to visits, transferring information, reduction of social and psychological risk, protection, team members accompanying clients, voluntary and involuntary admission/commitment, social interaction and networking, working with clients re integration into specific activities or the community in general, communication, interactive processes observed and interpreted as operating between clients, team members or others
MEDS	- medication work - generally to enquire about usage, to organize medication taking within a daily schedule, to observe or enquire about behaviour or side effects, relaying medication information between psychiatrists/nurses, clients families, others
NEEDS	- identifying individual client's needs, problems, difficulties, disadvantages
PERF	- addressing client competence, performance, function, ability, disability, skill associated with any aspect of everyday life
PLAN	- identifying individual client's goals, plans, purpose, progress, review of actions in discussions with team members, family members, clients, etc., change/lack of change from point of entry, progress in relation to plans
PSYCH	- attending to emotional and cognitive interests - intra-psychic, emotional reactions, cognitive processes associated with reasoning, decision making, planning, attitudes to self and others, judgement, self-concept, self-esteem, empathy, responsibility, assertiveness
RIGHT	- attending to client rights, access to charted information, access to decision making events and conversations, privacy, confidentiality
SAFE	- safety measures to avoid accidents, prevent injury, reduce risk, associated with <u>physical dangers</u> within the facility/program space (psychological risk covered in "LINK", "RIGHTS")
SPIR	- spiritual interests beyond "PSYCH" emotional matters - motivation, interests, sense of purpose, meaning, power, values, volition with or without a consciousness reference to a spiritual dimension (see also "NEEDS", "PLAN")
TERM	- acting and/or talking about client termination from the program/service, processes, plans, follow up, evaluation

(B) SITES, FORMS, INTERESTS IN EVERYDAY ACTIVITIES (ACTIVITIES OF DAILY LIVING)

- HOUS** - housing resources or specific housing situations of clients
- LEIS** - leisure resources or specific leisure situations, activities of clients, transportation associated with leisure
- LIFE** - overall life activities, not specific, pervasive, general, comprehensive e.g., transportation, relationships
- WAGE** - activities associated with preparing for or participating in waged work - pre-employment, employment, employment support & training resources, job hunting, specific employment situations of clients, checking stock, shopping for supplies or equipment, transportation associated with waged work, paid training, pre-employment
- SELF** - self care to attend to grooming, hygiene, weight, clothing, gestures/mannerisms, voice, family relations
- UNWA** - homemaking, child care: watering plants, checking stock of household supplies, transportation, kitchen, maintenance, unpaid pre-employment
- VOL** - work identified as voluntary, unpaid, outside the home but which are engaged in as a means of contributing to society, or of gaining possible work skills/attitudes/habits, or of fostering a sense of purpose akin to that associated with work, transportation associated with volunteer work

LABOUR CONTROL AND POWER: INSTITUTIONAL CONTROL STRAINING LOCAL POWER**(MANAGERIAL PROCESSES)**

- BIJD** - budget categories, gaps, changes, financial processes, petty cash
- CHART** - recording client information in charts, reports, "charting", letters on behalf of clients, assessments, policies regarding client access to charted information
- Eval** - occupational therapists' and other team members' work performance evaluation in the program, supervision, performance monitoring
- JOB** - job descriptions, descriptions of roles and responsibilities, duties associated within tasks and attitudes within or outside the program, division of labour with attention to ot skills, orientation, beliefs
- QUAL** - quality assurance activities

- MIS** - records of ot work or the work of others as it reflects or records indirectly the work of ot (mainly statistics, client charts) or record keeping policies, procedures, processes, statistics, program data, staff, clients organized into records of any type, filing, confidentiality, diagnostic classification, caseload management policies, case size expectations, **EXCLUDING TIME MANAGEMENT COVERED IN WMS**
- TEAM** - team systems of reporting, meetings, policies re team decision making versus individual staff decision making, team involvement in case management, hiring practices for the team
- WMS** - workload of team members as an entity, appointments, schedules, actions planned or required within a time frame, division of labour within the team or service system with attention to schedules, calculations of "caseload" and time to take on new clients, hours, breaks, overtime, sick leave, overall management of and accounting for **OT WORK TIME**
- UNION** - union work, participation in union activities, union policies and actions, work equivalence within union categories of workers

**CONSTRAINING OR ENABLING CLIENT EMPOWERMENT
(EDUCATIONAL PLAYERS, SITES, FORMS/PROCESSES OF WORK)**

(A) WITH "WHOM" ARE WORK PROCESSES COORDINATED?

- INDIV** - individual client contact
- GROUP** - group client contact, formal group, informal gathering of clients
- AD** - administrative personnel outside the team such as hospital or government administrators
- CL** - individual clients
- CLGR** - groups of clients where the group dynamic is of a collection of individuals working in parallel (talking in turn, or working on singular tasks/projects/actions), or as a unit (talking together, or working together on a single task/project/action)
- COM** - people in the "community" who are not paid by psychiatric/mental health services and who are paid by agencies or governments (e.g., employment or housing counsellors, recreation workers), in business (e.g., employers, landlords, merchants), or who are volunteers
- FA** - clients' family members, or significant support persons

- MI** - people who have been clients or who have had mental illnesses or problems but are not currently clients classified as "active" or "follow up", people who are in social recreation or self-help groups for those with mental illnesses
- OT** - occupational therapists outside the team, in psychiatric or non-psychiatric services
- OW** - on own - without anyone else present
- PRMH** - mental health professionals outside the identified team, such as consulting psychologists, social workers in community clinics, occupational therapists in other psychiatric programs
- TM** - members of the day program team including professional and non-professional members, and full or part time members, TM may be affixed after CL, CLGR, or any other category of person if team members are also present - e.g., CLGRTM would designate a process which focused on the ot being with a group of clients where one or more team members are present, TMCL would designate a process which focused on the ot being with team members where an individual client is present such as when a client is invited to a team meeting
- OTH** - any other person not covered by the categories above

(B) WORK SITES: "WHERE" ARE WORK PROCESSES ACCOMPLISHED?

- HM** - in a private home including a group residence such as a group home
- CM** - in a setting away from the central program location, e.g., an office in the community or another institution, in a church basement

(C) PROCESSES: "HOW" DO OT'S ACT IN CARRYING OUT THE PIECES OF THEIR WORK?

- CHECK** - looking at and/or talking about action, thought, conditions of another person - e.g., action taken with materials, such as a work or leisure project, report of phone calls made, letters written, conversations held, plans recorded, decisions/plans made, management of everyday life such as checking through a home visit - talk or action to take note of and comment on progress, completion **EXCLUDING ADVICE GIVING, SUGGESTIONS, ELICITATION OF PLANS TO GUIDE NEXT STEPS**, direct checking where the ot observes and asks about the actions/ideas of interest, indirect checking where the ot asks others' opinions or observations about a third party
- DEMO** - acting and/or talking while someone else is deliberately watching and with the intention of trying to do the same or similar action

- DESIG** - acting and/or talking to design or create new techniques, projects, plans
- EAT** - acting and/or talking associated with eating or drinking at breaks, lunch, or as part of an "activity" or "outing"
- EMPAT** - acting and/or talking to empathize with the client e.g., you seem to be feeling angry in a situation in which you've really been provoked (SIMILAR TO NURTURE, SUPPORT)
- ENCO** - acting and/or talking in ways to attempt to encourage individuals or groups to do or say NEW things that they are not currently doing or saying (e.g., suggesting that a client try doing something s/he isn't currently doing), (MAY BE CALLED COACHING)
- FIT** - acting and/or talking to "fit" (or re-fit) individuals or people in a group ("GROUP": THE SET OF PEOPLE IN A DAY PROGRAM, OR A SET OF PEOPLE ORIENTED TO A PARTICULAR PROJECT) to the program schedule and sessions, to a set of tasks which are part of a larger project, asking for volunteers to do "chores" within the program, assigning people to tasks which may or may not have a visible connection together but which the ot perceives need to be done to keep the facility/program running or to complete a project like making a meal, completing a leisure project, covering set up, action and clean up stages of a task OFTEN LINKED WITH "SCHED", BUT NOT NECESSARILY, MAY OR MAY NOT INCLUDE "NEG", OFTEN GOES WITH "TRANS"
- GUIDE** - acting and/or talking about what another person (or a number of people) is doing as the person proceeds with the task, project, action - suggesting additional, alternate, corrective actions, confirming actions, re-positioning materials periodically, comment on progress, highlight points of success, urge continuation, progression or finishing, physically altering or adding to products INCLUDES COACHING, PROMPTING, OVERSEEING
- HELP** - acting and/or talking to elicit help from others, as support from team members re decision making, re ideas/options, moral support
- INIT** - acting and/or talking to take initiative, i.e., be the person who makes the first move/says the first words, to start or stop actions or talk, doing or talking in ways not exhibited by others, introducing ideas or people to a situation
- INTER** - acting and/or talking to interpret, or re-interpret, perceptions or analysis of a situation, actions, behaviour, thoughts, re-phrasing what was already said
- JOIN** - acting and/or talking to join in a client conversation or activity as a participant/collaborator rather than as a leader, guide, teacher, therapist, guest, etc., e.g., cleaning a client's house with a group of other clients and team members, having coffee and preparing a speech with a client (this category might include role modelling)

- MENT** - mentoring, talking with clients about ot experiences and giving background for client to make decisions, guiding, supporting, empathizing
- MIRR** - acting and/or talking to provide a "mirror" for another person to see or think about themselves, giving reflective comments such as "you seem to uncertain in the way you are talking", or "you're someone who is well organized", may be **CONFRONTING** so that the mirror includes reflections which would not be considered by the person to be complimentary
- NEG** - acting and/or talking to define client labour assignment or division, asking for volunteers, suggesting assignment of tasks, listening to others' suggestions for assignment of tasks
- NOTE** - acting and/or talking to make written note of talk, e.g., writing points of what clients/team members/others are saying, writing notes of discussions on a flip chart, notes in client charts, notes on program ideas
- OBSER** - acting and/or talking to look at action and listen to talk of others, may be combined with "SOLIC", "QUES", "SPON", "NOTE", etc.
- PIECE** - a task, action, which is a "piece" of a total action (consciously or unconsciously linked to a larger goal/objective/purpose **LINKED WITH "PLAN"**, selecting a piece to match the ot's or client's perception of what is possible in light of perceived performance/competence, habits, psychological, spiritual strengths of an individual or group, selection assumes the importance and desirability of selecting a piece offering the possibility of a client experiencing positive feelings of "success", "enjoyment", "competence", "meaning" which contribute to a sense of "control and power to direct one's life"
- PRAIS** - acting and/or talking to praise the actions or talk of someone, "positive feedback", positive encouragement for what is **BEING DONE/SAID EXCLUDING "ENCO"** to prompt new action/talk, praise re risk-taking, such as after a client has responded in some way to "ENCO" (encouragement to try something new or difficult)
- PRES** - acting and/or talking to present program, illness, resource, & other information, ideas to others, possibly through lecture, through handing out written information sheets, through summarizing views and opinions (often goes with "SOLIC") so that the ot is asking for ideas and input, then presents something directly or indirectly reflective of material solicited (**PROVISION OF INFORMATION, RESOURCES**)
- REFER** - referring a client to services or people outside the program
- MESS** - acting and/or talking as a messenger, and translator, to report information from observation and/or participation in other actions/talk, conveying information gained through "SOLIC", "OBSER", "QUES", "CHECK", "TEST", reporting to individuals or groups

- REQ** - acting and/or talking to request action, discussion or decisions from others, e.g., give a urine sample, shop for supplies, talk to someone, asking someone to decide on plans
- ROLE** - acting and/or talking like someone else to portray behavioural and/or interactional characteristics - usually to simulate someone during a practice interaction with a client(s)
- SCHED** - acting and/or talking to order activities into a time frame, e.g., making lists of things to do and slotting actions into an appointment book, negotiating appointment times with clients/team members, etc., often goes with "FIT"
- SELL** - acting and/or talking to involve or arrange for others to sell products produced by clients, e.g., craft or work products produced as part of an activity program
- SETUP** - acting and/or talking in ways which prepare, adjust, or restore the physical, emotional or social environment of a situation, e.g., getting materials out and placing them before actions, cleaning up or adjusting a situation as actions progress, talking to people to inform them or set attitudinal tones before, during or after an action
- SHAD** - shadowing, accompanying a client to an event where the client is the actor, and the ot is the accomplice saying little and falling in behind the client, may include some COACH, MENT, ENCO
- SOLIC** - taking action or asking questions to solicit information, reflection, opinions, ideas based on a structured set of questions such as on an information form, client intake/initial/pre-admission assessment, alternate/referral/community service information, asking for feedback ideas e.g., "what do you think?", "how was that?", requesting information on other services conveyed through handout materials
- SPON** - acting and/or talking to back up/reinforce/support/emphasize/clarify what someone else has said, or which is put forward from ideas and talk gathered from someone else who wishes to have someone else articulate for her/him
- TEST** - using and/or talking about formal, organized procedures to find out information - e.g., using standardized assessment procedures to gather client information
- TRANS** - acting and/or talking in ways which transmit, transfer, link, bridge, and/or translate information or ideas from one source to another, including requesting or seeking information and conveying it to another person/group, etc., linking the day program with other services so that there is an extension of the day program ideas/approaches into other services
- TRAV** - acting and/or talking about moving by foot, car, taxi, other from the central program location to another location to carry out client/administrative or other actions, accompanying a client

APPENDIX C
ANALYTIC CATEGORIES RELATING WORK PROCESSES TO KEY FEATURES
IN LITERATURE
ON ENABLING EMPOWERMENT:

NOTES ON DEVELOPING CODES FOR THE THIRD ANALYTIC PROCESS
OF INSTITUTIONAL ETHNOGRAPHY

January, 1992

The analytic organization of work processes into three main organizational sections is leaving analysis of the work of enabling empowerment invisible. The original analytic idea was to describe the organization of occupational therapy by professional, managerial and community ideas. Reflection on the constraints and possibilities for enabling empowerment within this organization would follow. Analysis of the three main organizational forces has been scattered without a focus on which features in enabling empowerment are of particular interest. Reflections on enabling empowerment are repetitive and without focus since there is no focus for analysis of the three organizational forces.

A new analytic approach developed through committee discussions about the features of enabling empowerment which are most pertinent to occupational therapy. Analysis has shifted

dramatically and taken on new direction. An analytic set of code categories is developing around six key features which have become evident from re-reading observation and interview data and literature on enabling empowerment. In re-reading the coded sections of work processes, some work process coded segments were re-coded so that there are some code changes beyond those listed below. However, in general, work processes have now been re-coded into categories as follows:

CHAPTER THAT CODE	ANALYTIC CODE	WORK PROCESSES ASSOCIATED WITH	
3	DIAG		
4	COLLECTIVE	GROUP LEAD IND	COORD
5	CONTROL	CLASS PRODES INRES	
6	SIMULATION	INADL MODEL PSYEX	
7	RISK/LEGAL		
8	CONNECTIONS	REFER LOCAL	

APPENDIX D
RESEARCH INFORMATION SHEET

October, 1989

The following information describes research which will gather information about the day to day work of occupational therapists in community mental health day programs. This is not research about patients/clients.

What is the Purpose of the Research?

The purpose of this research is to describe and analyze what occupational therapists really do day by day in community mental health day programs to enable people to become more independent in managing everyday life. The information will be used:

1. by the researcher to improve the way occupational therapists are educated for working in the real, day to day conditions of community mental health day programs;
2. by staff of the day program in the ongoing development of occupational therapy services within this program.

Who is the Researcher?

Professor Elizabeth Townsend will be the researcher. She is a licensed occupational therapist who has worked in community mental health programs. She is a faculty member at the School of Occupational Therapy at Dalhousie University, Halifax, Nova Scotia (902-424-8804). She is conducting this research as part of her doctoral studies in education at Dalhousie University (902-424-3724).

How will the Research be Done?

Professor Townsend will attend the program full time for 6 - 8 weeks and will:

1. observe how the occupational therapist works with patients/clients in groups and individually;
2. observe occupational therapists in private interviews with patients/clients;
3. participate in activities and interviews according to the occupational therapist's instructions (participation in activities and interviews will be to lessen patient/client the anxiety of having an outsider present);
4. make notes on her observations after sessions are over (not during observation);
5. attend team meetings to hear how the occupational therapist and others talk about the work of the occupational therapist (participation in team meetings where suitable, she will contribute ideas in team meetings in acknowledgement of the contribution which those in the day program are making to her research);
6. tape record individual, weekly 1 hour interviews with the occupational therapist;
7. tape record one or two individual 1 hour interviews (as needed by the researcher but also as team time permits) with each of the people with whom she has observed me working including other team members, the coordinator/supervisor, community workers; if the team and patients/clients give permission, she will interview up to 10 of patients/clients or family members;
8. make notes from patient/client records for those patients/clients with whom she has observed the occupational therapist working;
9. make notes from occupational therapy assessment and discharge reports if these exist separately from the general patient/client record;

10. make copies of documents which record the last 12 months of occupational therapy practice such as: statistical and case management blank forms and actual records including Workload Measurement System records; monthly and annual records of numbers of clients/patients, diagnostic categories, functional problems, types of services, number of home visits; appointment books, schedules and lists which document appointments and case management;
11. make copies of up to 3 years of administrative materials which have in the past and now direct occupational therapy practice, such as policy manuals and written procedures, schedules, memoranda, letters, mission statements, publicity information, community follow up resource materials;
12. make copies of up to 3 years of forms and actual documents which have in the past and now give the occupational therapy job description, and job descriptions of other team members; actual financial statements which indicate occupational therapy categories and levels of expenditure for occupational therapy equipment and supplies (this may be available in annual reports);
13. revisit each site for a short time (a few days scheduled as mutually suitable to the researcher and the team) after the initial data collection has been completed at each site (revisits might include observation, interviews, document review as needed to clarify outstanding questions);
14. review and get input on the interim and final written analysis with team members in each site; verbally review and get input on the analysis from patients/clients and others who have contributed to the study.

How will the Researcher Keep Confidentiality?

Professor Townsend will follow all confidentiality rules for the day program and will strictly guard all information from the study. She will:

1. not discuss any information on any patients/clients outside the day program;
2. code dictated and written notes which refer to particular treatment sessions such that no one else will be able to trace her notes to specific patients/clients;
3. refer to any specific patients/clients only by a pre-determined code in tape recorded interviews;
4. not write on any patient/client records;
5. keep all interview tapes, notes from patient/client records, and other data in a safe place at the day program or in locked files in her office;
6. personally transcribe all interview and other tape recorded information;
7. study interview tapes, notes from patient/client records, and other data in a private place in the day program or alone in her office;
8. discuss her data and analysis with her supervisory committee only as coded, without reference to specific individuals;
9. return all notes from patient/records after the study is finished to the day program coordinator who will oversee that they are safely destroyed;
10. erase all interview tapes to the satisfaction of the person whose interview was recorded on each tape, i.e., the occupational therapist, other team members, managers, patients/clients, or family members;
11. discuss her observations and analysis specific to the occupational therapist or other team members only with those specific individuals; she will in no way allow any of her information to be used in evaluation of any team member;

12. participate in informal discussion of occupational therapy work with the team coordinator only in the presence of the occupational therapist and only if both parties make the invitation to participate;
13. refer, in her verbal and written discussions of this research, to occupational therapy work in day programs in Atlantic Canada with no specific reference to sites people, or even to the Province in which this study was done (we may jointly develop an alternate pseudonym to "Atlantic Canada OT Study");
14. not identify any specific individuals in any written records or reports.

How Would Difficulties be Resolved?

If any person is dissatisfied with this research, they should attempt to resolve any difficulties directly with Professor Townsend. Should this be unsuccessful, they should discuss difficulties with the team coordinator who will attempt to mediate a resolution. If necessary, the team coordinator will include in mediation the study Supervisor, Dr. A. Manicom, School of Education, Dalhousie University, Halifax, 902-424-3724.

APPENDIX E

OCCUPATIONAL THERAPIST CONSENT FORM

(Consent will be requested by the Coordinator/Supervisor)

The following consent refers to the research described on the sheet "PROFESSIONAL PRACTICE AND EMPOWERMENT: RESEARCH INFORMATION". The information sheet describes research which will gather information about occupational therapy practice in community mental health day programs. This is not research about patients/clients.

What consent am I giving?

I consent to the following assuming Professor Townsend will keep full confidentiality and resolve any difficulties as described in the information sheet;

1. She may observe my work during group patient/client treatment sessions inside day program facilities or outside in the community;
2. She may observe and participate in private patient/client interviews at my discretion and when I and the patient/client have given consent for this particular session beyond the general consent given by this patient/client and myself;
3. She may participate in my work with patients/clients according to my instructions on the appropriate level and type of participation;
4. She may make notes on my team and personnel patient/client records to study how I write about my work;
5. She may attend team meetings to hear how I talk to other professionals about my work;
6. She may tape private interviews with other team members to hear how they talk about occupational therapy work;
7. She may tape private interviews with me.

What are my Rights?

I have the right to:

1. ask Professor Townsend to leave any patient/client session or to change the level and type of her participation;
2. terminate my participation in this study if difficulties arise and mediation attempts described above are not successful;
3. check the erasing of tapes and destruction of materials after the study has been completed.

I agree to take part in this study.

Signed: _____ Date: _____

(Occupational Therapist)

Signed: _____ Date: _____

(Day Program Coordinator/Supervisor)

APPENDIX F

OCCUPATIONAL THERAPISTS INTERVIEW GUIDE

As is the practice in qualitative research, I will develop interview questions during the study as observations raise questions. I will not pre-determine categories and questions until these are defined through preliminary analysis of the observation data. The interviews will be exploratory, asking for clarification and explanations of observations. Questions will be grounded in specific, documented data. Therefore, no finalized interview guides will be prepared prior to the study. However, I will be interviewing people in order to understand the invisible categories, ideas, concepts, values and beliefs which determine how the work of these people intersects and coordinates with the work of occupational therapy. General question areas are listed in this outline.

The occupational therapy interviews will ask about any observed work but will focus most specifically on educational processes which might be associated with enablement/empowerment. A possible categorization of educational processes has been chosen to illustrate the types and examples of questions.

A. DESCRIPTION OF EDUCATIONAL ACTIONS ASSOCIATED WITH 5 PURPOSES IN EVERYDAY PRACTICE

Overview and Summary

Of the actions you have taken this week which you would consider to be in any way and in the broadest sense "educational" with your clients/patients/support people/family (those other than your fellow workers)?

- what was it about those actions which made them "educational"? how would you describe the learning process which you intended? as it turned out? what would you say influenced the difference between what you intended and what happened?

1. "Participation and doing"

Of the actions you have taken this week which you would consider to be in any way and in the broadest sense requiring "participation or doing" by clients/patients/support people/family (those other than your fellow workers)?

- **what was it about those actions which made them require "participation or doing"? how would you describe the "participation or doing" which you intended? as it turned out? what would you say influenced the difference between what you intended and what happened?**

2. "Developing a sense of self-competence"

Of the actions you have taken this week which you would consider to be in any way and in the broadest sense "developing a sense of self-competence" in clients/patients/support people/family (those other than your fellow workers)?

- **what was it about those actions into "developing a sense of self-competence"? how would you describe the "developing a sense of self-competence" which you intended? as it turned out? what would you say influenced the difference between what you intended and what happened?**

3. "Critical reflection"

Of the actions you have taken this week which you would consider to be in any way and in the broadest requiring "critical reflection" by clients/patients/support people/family (those other than your fellow workers)?

- **what was it about those actions which made them require "critical reflection"? how would you describe the "critical reflection" which you intended? as it turned out? what would you say influenced the difference between what you intended and what happened?**

4. "Development of individual or collective resources"

Of the actions you have taken this week which you would consider to be in any way and in the broadest sense requiring "development of individual or collective resources" with clients/patients/support people/family (those other than your fellow workers)?

- what was it about those actions which made them require "development of individual or collective resources"? how would you describe the "development of individual or collective resources" which you intended? as it turned out? what influenced the difference between what you intended and what happened?

5. "Collaboration"

Of the actions you have taken this week which you would consider to be in any way and in the broadest sense requiring "collaboration" with clients/patients/support people/family (those other than your fellow workers)?

- what was it about those actions which made them require "collaboration"? how would you describe the "collaboration" which you intended? as it turned out? what would you say influenced the difference between what you intended and what happened?

B. INTERSECTION WITH OTHER PRACTICES

Linkages between therapists' actions and the actions of 2 clients/patients in individuals or groups observed during 1 week:

1. By what process did you become aware of the needs of 2 of the individuals or groups involved in the particular educational processes you identified above? What was clear, confusing or contradictory about these needs as you perceived them?

2. **What process of thinking did you go through to translate your awareness of needs of the 2 individuals or groups into the particular educational actions you described associated with those particular individuals or groups? What alternative options did you consider? Why did you accept the one(s) you took and why did you reject the other alternatives?**
3. **How did you become aware of different or changing needs in these 2 individuals or groups as you proceeded with these particular educational actions? What became clear and consistent with your initial perceptions, or more confusing and contradictory than you had perceived?**
4. **What differences or changes in awareness in needs would you associate with changes in the educational actions discussed above with reference to these particular 2 individuals or groups? What alternative options did you consider? Why did you accept the one(s) you took and why did you reject the other alternatives?**

Linkages between therapists' actions and the actions of other workers and support persons observed during 1 week:

1. **In what ways did the educational actions associated with the 2 individuals or groups which you have been discussing bring you in contact with other workers and support people (nature and methods of interaction)?**
Why did you interact with these people?
What historical developments are you aware of that have led to you interacting as you did?
 - **with other professional team members?**
 - **with non-professional team members?**
 - **with professionals outside your team?**

- with administrators outside your team?
- with community support people?
- with family and other support people?

C. DOCUMENTARY PRACTICES

1. **What documents influenced the particular educational actions taken with the 2 individuals or groups which you have been discussing?**
 - policies, memoranda, letters? who wrote each of these? how long ago were they written? what developmental stages (if any) did the writing go through as far as you know? who was involved in the developmental stages (if any)?
 - how did these policies, etc., determine these particular actions? what differences were there in the way you had to interpret the policies, etc. for these particular actions?
2. **Where, when and how did you document information on these particular actions taken with the 2 individuals or groups which you have been discussing?**
 - routines involved in documenting these particular actions? what standards were you required to meet? who monitors a) quantity, and b) quality of the documentation for these actions? how do they do it? under what conditions of time and space did you do this particular documenting?

APPENDIX G

INSTRUMENT FOR AUDITING PATIENTS' HEALTH RECORD

<u>OCCUPATIONAL THERAPY</u>	YES	NO	N/A	Percent Time Criterion Met	Comment
<u>I. Identification</u>					
a) Is the patient's name on each face of the record?					
b) Is the patient's chart number on each face of the record?					
<u>II. Referral</u>					
a) Is reason for referral to O. T. documented on the first page of the O. T. record?					
b) Is the referral authorized by a physician through 1) <u>written authorization</u> (Doctor's order sheet, referral or consult form signed by doctor) or 2) by documentation of a physician's <u>verbal referral</u> ? Exemption - services with standing orders.					
c) Is the date of referral documented on the first page of the O. T. record?					
d) Is the response to the receipt of referral documented?					
e) Was the response within two working days of the referral?					

June 1987.

Occupational Therapy DepartmentChart Audit Instrument

OCCUPATIONAL THERAPY

	Yes	No	N/A	Percent Time Criterion Met	Comment
III. <u>Time Reference</u>					
a) <u>Is each new entry dated?</u>					
IV. a) <u>Evaluation Method(s)</u>					
- Is the method(s) of evaluation stated (i.e. interview, standardized tests, observation, chart research, collateral sources)?					
b) <u>Summary of Assessment(s)</u>					
- Is there an identification of strengths and deficits and their implications?					
c) <u>Goals</u>					
- Are treatment goals identified?					
V. a) <u>Intervention Plan</u>					
- Are the individual/group programs documented along with the anticipated frequency of participation?					
b) <u>Frequency of Contact</u>					
- Is the intended frequency of direct contact documented?					
c) <u>Progress Note(s)</u>					
- According to service frequency, are the following, where appropriate, included: outcomes of intervention; recommendations directly related to previously identified goals; restatement or statement of changes /additions to goals; further intervention plans (including frequency of contact).					

Occupational Therapy Department

Chart Audit Instrument

OCCUPATIONAL THERAPY

	Yes	No	N/A	Percent Time Criterion Met	Comment
<p>V. d) <u>Discharge Summary/Statement</u></p> <p>- Is the functioning level at the time of discharge and anticipated action or recommendations indicated?</p>					
<p>VI. <u>Frequency of Documentation</u></p> <p>Is frequency of documentation in accordance with established guidelines for each assigned service? (See attached guidelines, Appendix A)</p> <p>Assigned Services are:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>TOTAL</p>					
<p>VII. <u>Signature</u></p> <p>a) Following each chart entry, is the surname and initial of the recording therapist printed and signed?</p>					
<p>b) Is each signature followed by the designation of O.T. REG. (N.S.)?</p>					

Occupational Therapy Department
Chart Audit Instrument

OCCUPATIONAL THERAPY	YES	NO	N/A	Percent Time Criterion Met	Comment
VIII. <u>Corrections</u>					
a) Are corrections made according to the standards (crossed out, dated, initialed)?				-	

BIBLIOGRAPHY

- Adamson, W.R. (1990). Empowering disciples: Adult education in the church. BC: Winfield: Novalis/Wood Lake Books.
- American Psychiatric Association (1987). Diagnostic and statistical manual of mental disorders: DSM III-R. Washington, DC: American Psychiatric Association.
- Anthony, W., Cohen, M., & Cohen, B. (1983). Philosophy, treatment process, and principles of the psychiatric rehabilitation approach. New Directions for Mental Health Services, 6, 67-78.
- Apple, M.W. (1986). Teachers and texts: A political economy of class and gender relations in education. New York: Routledge and Kegan Paul.
- Ayres, A.J. (1981). Sensory integration and the child. Los Angeles, CA: Western Psychological Press.
- Bachrach, L.L. (1977). Deinstitutionalization: A conceptual framework. Rockville, MD: NIMH.
- Bachrach, L.L. (1988). Treating chronically mentally ill women. Washington, D.C.: American Psychiatric Press.
- Baily, R., & Brake, M. (1975). Radical social work. New York: Pantheon Books.
- Baker, F. (1977). The interface between professionals and natural support systems. Clinical Social Work Journal, 5, 139-148.
- Banus, B.S. (1979). The developmental therapist. 2nd Ed. Thorofare, NJ: Slack.
- Bateson, M.C. (1989). Composing a life. New York: Plume.
- Beard, J., Propst, R., & Malamud, T. (1982). The fountain house model of psychiatric rehabilitation. Psychosocial Rehabilitation Journal, V(1), 47-53.
- Belenky, M.F., Clinchy, B.M, Goldberger, N.R., & Tarule, J.M. (1986). Women's ways of knowing: The development of self, voice and mind. New York: Basic Books Publishers.
- Benzing, P., & Strickland, R. (1983). Occupational therapy in a community based prevention program. Occupational Therapy in Mental Health, 3(1), 15-30.
- Berger, P.L., & Neuhaus, R.J. (1977). To empower people: The role of mediating structures in public policy. Washington, D.C.: American Enterprise Institute for Public Research Policy Research.

- Bernstein, R.J. (1983). Beyond objectivism and relativism: Science, hermeneutics and praxis. Oxford: B. Blackwell.
- Berry, M., Carver, J., Gayler, C., Loewen, J., Murphy, M., & Parkinson, W. (1988). Psychosocial rehabilitation in the Ontario context. (UnPub)
- Biegal, D.E., & Naparstek, A.J. (1982). Community support systems and mental health: Practice, policy, and research. New York: Springer Publishing Company.
- Blain, J., Townsend, E., Krefting, L., & Burwash, S. (1992). Impact study: Evaluation and recommendations. Toronto, ON: Canadian Association of Occupational Therapists.
- Bockoven, J.S. (1971). Legacy of moral treatment-1800's to 1900's. American Journal of Occupational Therapy, 25, 223-226.
- Braithwaite, R.L., & Lythcott, N. (1989). Community empowerment as a strategy for health promotion for Black and other minority populations. Journal of the American Medical Association, 261, 282-283.
- Braverman, H. (1975). Labour and monology capital: The degradation of work in the 20th century. New York: Monthly Review Press.
- Breines, E.B. (1987). Pragmatism as a foundation for occupational therapy curricula. American Journal of Occupational Therapy, 41, 522-525.
- Breines, E.B. (1989). Development, change and continuity theories: An analysis. Canadian Journal of Occupational Therapy, 56, 109-112.
- Brook, R.H., & Appel, F.A. (1973). Quality of care assessment: Choosing a method for peer review. New England Journal of Medicine, 288, 1323-1329.
- Brookfield, S.D. (1986). Understanding and facilitating adult learning. San Francisco, CA: Jossey-Bass Publishers.
- Brookfield, S.D. (1987a). Developing critical thinkers. San Francisco, CA: Jossey-Bass Publishers.
- Brookfield, S.D. (1987b). Learning Democracy: Eduard Lindeman on adult education and social change. London, England: Croom Helm.
- Brosio, R.A. (1990). Teaching and learning for democratic empowerment: A critical evaluation. Educational Theory, 40, 69-81.
- Brown, L.D. (1985). People-centred development and participatory research. Harvard Educational Review, 55, 69-75.
- Brown, K., & Gillespie, D. (1992). Recovering relationships: A feminist analysis of recovery models. American Journal of Occupational Therapy, 46, 1001-1005.

- Bucher, R., & Strauss, A. (1961). Professions in process. American Journal of Sociology, 66, 325-334.
- Caffarella, R.S., & O'Donnell, J.M. (1980). Self-directed adult learning: A critical paradigm revisited. Adult Education Quarterly, 37(4), 199-211.
- Campbell, D. (1980). The unit value system: If you're not interested you should be. Canadian Journal of Occupational Therapy, 47, 27-29.
- Campbell, M.L. (1984). Information systems and management of hospital nursing: A study in social organization of knowledge. University of Toronto, Toronto: Unpublished Doctoral Thesis.
- Canada (1982). Canadian charter of rights and freedoms, Constitution Act, Part I. Ottawa: Supply and Services Canada.
- Canadian Association of Occupational Therapists (1968). Announcement, Canadian Journal of Occupational Therapy, 35(2), p. 52.
- Canadian Association of Occupational Therapists (1988). Membership Data - 1987. The National, May, Centrefold.
- Canadian Association of Occupational Therapists (1991). Occupational therapy guidelines for client-centred practice. Toronto, ON: Author.
- Canadian Association of Occupational Therapists. (1993a). Occupational therapy guidelines for client-centred mental health practice. Author.
- Canadian Association of Occupational Therapists (1993b). Membership Data - 1992. The National, May, Centrefold.
- Canadian Association of Occupational Therapists (1993c). Report of Seniors Health Promotion Project, Toronto, ON: Author.
- Canadian Association of Occupational Therapists (1993d). Code of Ethics. Toronto, ON: Author.
- Canadian Association of Occupational Therapists (1994). Occupational Therapist - Functional Analysis (OT-FA). Toronto, ON: Author.
- Canadian Communications Consulting Group (1993). National Occupational Classification. Ottawa, ON: Author - Publishing, Cat. MP53-25/2-1993E.
- Caplow, T. (1978). The sociology of work. Westport, CON: Greenwood Press.
- Carr, W., & Kemmis, S. (1986). Becoming critical: Education, knowledge and action research. London: Falmer Press.

- Carswell-Opzoomer, A. (1990). Muriel Driver Memorial Lecture: Occupational therapy - our time has come. Canadian Journal of Occupational Therapy, 57, 197-203.
- Cassin, A.M. (1984). Management: A textually mediated social organization. (UnPublished Manuscript)
- Cassin, A.M. (1990). The routine production of inequality: A study in the social organization of knowledge. Toronto: Doctoral Thesis, University of Toronto.
- Checkoway, B., & Norsman, A. (1986). Empowering citizens with disabilities. Community Development Journal, 21, 270-277.
- Chesler, P. (1972). Women and madness. New York: Avon Books.
- Chilton, H. (1990). Managed or be managed: Where do you stand? Reflections on... Canadian Journal of Occupational Therapy, 57, 167-169.
- Christiansen, C., & Baum, C. (1991). Occupational therapy: Overcoming human performance deficits. Thorofare, NJ: Slack.
- Clark, F.A., Parham, D., Carlson, M.E., Frank, G., Jackson, J., Pierce, D., Wolfe, R.J., & Zemke, R. (1991). Occupational science: Academic innovation in the service of occupational therapy's future. American Journal of Occupational Therapy, 45, 300-310.
- Coalition of Provincial Organizations of the Mentally Handicapped (COPOH) (1986). Defining the parameters of independent living. Winnipeg: MN.
- Coburn, D. (1988). Canadian medicine: Dominance or proletarianization?. The Milbank Quarterly, 66(2), 92-116.
- Coburn, D., D'Arcy, C., Torrence, G.M., & New, P. (1987). Health and Canadian society: Sociological perspectives. Markham, Ontario: Fitzhenry and Whiteside.
- Cockerham, W.C. (1989). Sociology of mental disorder. 2nd Ed. Englewood Cliffs, NJ: Prentice-Hall.
- Cohen, S., & Scull, A. (1983). Social control and the state. New York: St. Martin's Press.
- Cohn, E.S. (1991). Clinical reasoning: Explicating complexity. American Journal of Occupational Therapy, 45, 969-971.
- Collard, S., & Law, M. (1989). The limits of perspective transformation: A critique of Mezirow's theory. Adult Education Quarterly, 39, 99-107.
- Community Occupational Therapy Associates. (1982). A graduated discharge program: West Park Hospital Neuro-rehabilitation Unit. A study conducted by Community Occupational Therapy Associates.

- Conger, J.A., & Kanungo, R.N. (1988). The empowerment process: Integrating theory and practice. Academy of Management Review, 13, 471-482.
- Conrad, P., & Schneider, J.W. (1980). Deviance and medicalization: From badness to sickness. St. Louis: Mosby.
- Cook, J. (1988). Goffman's legacy: The elimination of the chronic mental patient's community. A review of selected literature. Research in the Sociology of Health Care, 7, 249-281.
- Cox, F.M., Erlich, J.L., Rothman, J., & Tropman, J.E. (Eds.) (1979). Strategies of community organization. 3rd Ed. Itasca: F. E. Peacock Publishers, Inc..
- Crepeau, E.B. (1991). Achieving intersubjective understanding: Examples from an occupational therapy treatment session. American Journal of Occupational Therapy, 45, 1016-1025.
- Crompton, R. (1987). Gender, status and professionalism. Sociology, 21(3), 413-428.
- Cromwell, F.S. (1977). Eleanor Clarke Slagle, the leader, the woman. American Journal of Occupational Therapy, 31, 645-648.
- Cynkin, S. (1979). Occupational therapy: Toward health through activities. Boston, MA: Little, Brown and Company.
- Cynkin, S., & Robinson, A.M. (1990). Occupational therapy and activities health: Toward health through activities. Boston: Little, Brown and Company.
- Dasler, P. (1984). Deinstitutionalizing the occupational therapist. Occupational Therapy in Health Care, 1(1),
- Daudi, P. (1986). Power in the organization: The discourse of power in managerial praxis. Oxford: Blackwell.
- De Jong, G. (1979). Independent living: From social movement to analytic paradigm. Archives of Physical Medicine and Rehabilitation, 60, 435-446.
- de la Boetie, E. (1975). The politics of obedience: The discourse of voluntary servitude. Montreal: Black Rose Books.
- Department of National Health and Welfare (1985). Occupational therapy workload measurement system. Ottawa, ON: Author.
- Department of National Health and Welfare (1986). Achieving health for all: A framework for health promotion 39-102/1988E. Ottawa, ON: Author.
- Department of National Health and Welfare (1988). Mental health for Canadians: Striking a balance H39-128/1988E. Ottawa, ON: Author.

- Department of National Health and Welfare, & Canadian Association of Occupational Therapists Task Force. (1983). Guidelines for the client-centred practice of occupational therapy H39-33/1983E. Ottawa, ON: Department of National Health and Welfare.
- Department of National Health and Welfare, & Canadian Association of Occupational Therapists Task Force. (1986). Intervention guidelines for the client-centred practice of occupational therapy H39-100/1986E. Ottawa, ON: Department of National Health and Welfare.
- Department of National Health and Welfare, & Canadian Association of Occupational Therapists Task Force. (1987). Toward outcome measures in occupational therapy H39-114/1987E. Ottawa, ON: Department of National Health and Welfare.
- Derber, C. (1982). Professionals as workers: Mental labour in advanced capitalism. Boston: A.K. Hall and Company.
- Devereaux, E.B. (1991). Community-based practice. American Journal of Occupational Therapy, 45, 944-946.
- Dill, B.T. (1987). The dialectics of black womanhood. In S. Harding. Feminism and methodology. pp. 97-108. Bloomington, IN: Indiana University Press.
- Dillard, M., Andonian, L., Flores, O., Lai, L., MacRae, A., & Shakir, M. (1992). Culturally competent occupational therapy in a diversely populated mental health setting. American Journal of Occupational Therapy, 46, 721-726.
- Dingwall, R., & Lewis, P. (1983). Sociology of the professions: Lawyers, doctors and others. New York: St. Martin's Press.
- Doerner, K. (1981). Madmen and the bourgeoisie: A social history of insanity and psychiatry. Oxford: Basil Blackwell.
- Donabedian, A. (1966). Evaluating the quality of medical care. Milbank Memorial Fund Quarterly, 44, 166-206.
- Douglas, J.D. (1970). Understanding everyday life: Toward the reconstruction of sociological knowledge. Chicago: Aldine Publishing Company.
- Driver, M. (1968). A philosophic view of the history of occupational therapy in Canada. Canadian Journal of Occupational Therapy, 35, 53-60.
- Druker, P. (1993). Post-capitalist society. New York: Harper Business.
- Dunst, C.J., & Trivette, C.M. (1989). An enablement and empowerment perspective of case management. Topics in Early Childhood Special Education, 8, 87-102.
- Dunst, C.J., Trivette, C., Davis, M., & Cornwell, J. (1988). Enabling and empowering families of children with health impairments. Children's Health Care, 17, 71-81.

- Dunton, W.R. (1919). Reconstruction therapy. Philadelphia: Saunders.
- Dyck, I. (1992). Managing chronic illness: An immigrant woman's acquisition and use of health care knowledge. American Journal of Occupational Therapy, 46, 696-705.
- Eakin, J.M. (1984). Survival of the fittest? The democratization of hospital administration in Quebec. International Journal of Health Services, 14, 397-412.
- Ehrenreich, J. (1978). The cultural crisis of modern medicine. New York: Monthly Review Press.
- Ehrenreich, B., & English, D. (1979). For her own good: 150 years of the experts' advice to women. Garden City, New York: Anchor Press.
- Eisler, R. (1988). The chalice and the blade: Our history, our future. San Francisco: Harper & Row.
- Ellen, R.F. (1984). Ethnographic research: A guide to general conduct. London: Academic Press.
- Ellsworth, E. (1989). Why doesn't this feel empowering? Working through the repressive myths of critical pedagogy. Harvard Educational Review, 59(3), 297-324.
- Etzioni, A. (1964). Modern organizations. New Jersey: Prentice Hall.
- Etzioni, A. (1969). The semi-professions and their organization: Teachers, nurses, social workers. New York: The Free Press.
- Evans, J., & Salim, A.A. (1992). A cross-cultural test of the validity of occupational therapy assessments with patients with schizophrenia. American Journal of Occupational Therapy, 46, 685-695.
- Fay, B. (1987). Critical social science: Liberation and its limits. New York: Cornell University Press.
- Felton, B.J., & Shinn, M. (1981). Ideology and practice of deinstitutionalization. Journal of Social Issues, 37, 158-172.
- Fidler, G.S., & Fidler, J.W. (1978). Doing and becoming: Purposeful action and self-actualization. American Journal of Occupational Therapy, 32, 305-310.
- Fisher, S., & Todd, A.D. (1986). Discourse and institutional authority: Medicine, education and law. Norwood, New Jersey: Ablex Publishing Corp..
- Fleming, M.H. (1991). The therapist with the three tract mind. American Journal of Occupational Therapy, 45, 1007-1014.

- Florin, P., & Wandersman, A. (1990). An introduction to citizen participation, voluntary organizations, and community development: Insights for empowerment through research. American Journal of Community Psychology, 18, 41-54.
- Forester, J. (1980). Listening: The social policy of everyday life (critical therapy and hermeneutics in practice). Social Praxis, 7, 219-232.
- Foucault, M. (1965). Madness and civilization: A history of insanity in the age of reason. New York: Pantheon Books.
- Foucault, M. (1972). Power/knowledge: Selected interviews and other writings, 1972-1977. Gordon, C. (Ed.), Transl. by C. Gordon, L. Marshall, J. Mepham, K. Soper. Brighton: Harvester Press.
- Frank, G. (1992). Opening feminist histories of occupational therapy. American Journal of Occupational Therapy, 46, 989-999.
- Freidson, E. (1986). Professional powers: A study of the institutionalization of formal knowledge. Chicago: University of Chicago Press.
- Freire, P. (1970). Pedagogy of the oppressed: The letters to Guinea-Bissau. New York: Continuum Books.
- Freire, P. (1972). Cultural action for freedom. Harmondsworth: Penguin Books.
- Freire, P. (1973). Education for critical consciousness. New York: Continuum Books.
- Freire, P. (1976). Education: The practice of freedom. London: Writers and Readers.
- Freire, P. (1985). The politics of education: Culture, power and liberation, Transl. by D. Macedo. Massachusetts: Bergin & Garvey Publishers, Inc.
- Friedland, J., & Renwick, R.M. (1993). The Issue Is - Psychosocial occupational therapy: Time to cast off the gloom and doom. American Journal of Occupational Therapy, 47, 467-471.
- Garfinkel, H. (1967). Studies in ethnomethodology. Englewood Cliffs, NJ: Prentice-Hall.
- Gibson, C.H. (1991). A concept analysis of empowerment. Journal of Advanced Nursing, 16, 354-361.
- Giddens, A. (1984). The constitution of society: Outline of the theory of structuration. Berkeley, CA: University of California Press.
- Giddens, A. (1991). Modernity and self-identity: Self and society in the late modern age. Stanford, CA: Stanford University Press.
- Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge, MA: Harvard University Press.

- Glaser, B. (1978). Theoretical sensitivity. San Francisco: The Sociology Press.
- Goffman, E. (1961). Asylums: Essays on the social situation of mental patients and other inmates. New York: Anchor Press.
- Gottlieb, B.H., & Coppard, A.E. (1987). Using social network therapy to create support systems for the chronically mentally disabled. Canadian Journal of Community Mental Health, 6(2), 117-131.
- Gough, I. (1979). Political economy of the welfare state. London: MacMillan Press.
- Grace, V.M. (1991). The marketing of empowerment and the construction of the health consumer: A critique of health promotion. International Journal of Health Services, 21, 329-343.
- Grady, A.P. (1992). Occupation as vision. American Journal of Occupational Therapy, 46, 1062-1065.
- Gruber, J., & Trickett, E.J. (1987). Can we empower others? The paradox of empowerment in the governing of an alternative public school. American Journal of Community Psychology, 15, 353-371.
- Guba, E.G., & Lincoln, Y.S. (1989). Fourth generation evaluation. Newbury Park: Sage Publications.
- Gutting, G. (1989). Michel Foucault's archaeology of scientific reason. Cambridge: Cambridge University Press.
- Habermas, J. (1973). Theory and practice. Translated by J. Viertel. Boston: Beacon Press.
- Habermas, J. (1984). The theory of communicative action: Volume 1, reason and the rationalization of society. Boston: Beacon Press.
- Hall, B.L. (1981). Participatory research, popular knowledge and power: A personal reflection. Convergence, 3, 6-17.
- Hamlin, R.B. (1992). Embracing our past, informing our future: A feminist re-vision of health care. American Journal of Occupational Therapy, 46, 1028-1035.
- Hamlin, R.B., Loukas, K.M., Froehlich, J., & MacRae, N. (1992). Feminism: An inclusive perspective. American Journal of Occupational Therapy, 46, 967-970.
- Hammersley, M., & Atkinson, P. (1983). Ethnography: Principles and practice. New York: Tavistock publications.
- Harding, S. (1986). The science question in feminism. Ithaca: Cornell University Press.
- Harding, S. (1987). Feminism and methodology. Bloomington: Open University Press.

- Hawks, J.H. (1991). Power: A concept analysis. Journal of Advanced Nursing, 16, 754-762.
- Hearn, J. (1982). Notes on patriarchy, professionalization and the semi-professions. Sociology, 16, 184-202.
- Holland, A. (1972). Professionalization as an historical concept. Lock Haven Review, 13, 52-57.
- Hollingshead, A.B., & Redlich, F.C. (1958). Social class and mental illness. New York: John Wiley and Sons.
- Hopkins, H.L., & Smith, H.D. (1988). Willard and Spackman's Occupational Therapy. 7th Ed. Philadelphia: J.P. Lippincott.
- Houston, B. (1988). Gilligan and the politics of a distinctive women's morality. In L. Code, S. Mullett & C. Overall. Feminist perspectives: Philosophical essays on method and morals. pp. 168-189. Toronto: University of Toronto Press.
- Houston, D., Williams, S.L., Bloomer, J., & Mann, W.C. (1989). The Bay Area Functional Performance Evaluation: Development and standardization. The American Journal of Occupational Therapy, 43, 170-183.
- Howell, E., & Bayes, M. (1981). Women and mental health. New York: Basic Books, Inc.
- Howland, G.W. (1944). Occupational therapy across Canada. Canadian Geographical Journal, 28(1), 32-40.
- Hughes, E.C. (1958). Men and their work. New York: The Free Press of Glencoe.
- Ignatieff, M. (1984). The needs of strangers: An essay on privacy, solidarity and the politics of being human. New York: Penguin Group.
- Illich, I. (1978). Toward a history of needs. New York: Pantheon Books.
- Illich, I., Zola, I.K., McNight, J., Caplan, J., & Shaiken, H. (1977). Disabling professions. London: Marion Boyers.
- Ingleby, D. (1981). Critical psychiatry: The politics of mental health. Middlesex: Penguin.
- Johnson, T.J. (1972). The professions and power. London: Macmillan Press.
- Johnson, J.A., & Yerxa, E.J. (1989). Occupational science: The foundation for new models of practice. New York: Haworth.
- Jongbloed, L., & Crichton, A. (1990). A new definition of disability: Implications for rehabilitation practice and social policy. Canadian Journal of Occupational Therapy, 57, 32-38.

- Kari, N., & Michels, P. (1991). The Lazarus project: The politics of empowerment. American Journal of Occupational Therapy, 45, 719-725.
- Katz, R. (1984). Empowerment and synergy: Expanding the community's healing resources. Prevention in Human Services, 3, 201-226.
- Kidd, J.R. (1973). How adults learn. New York: Association Press.
- Kieffer, C. (1984). Citizen empowerment: A developmental perspective. Prevention in Human Services, 3, 9-36.
- Kielhofner, G. (1983). Health through occupation: Theory and practice in occupational therapy. Philadelphia: F.A. Davis Company.
- Kielhofner, G. (1985a). A model of human occupation: Theory and application. Baltimore, MD: Williams and Wilkins.
- Kielhofner, G. (1985b). The demise of diffidence: An agenda for occupational therapy. Canadian Journal of Occupational Therapy, 52, 165-171.
- Kielhofner, G. (1992). Conceptual foundations of occupational therapy. Philadelphia: F.A. Davis.
- Kielhofner, G. (1993). The Issue Is - Functional assessment: Toward a dialectical view of person-environment relations. American Journal of Occupational Therapy, 47, 248-251.
- Kilian, A. (1988). Conscientization: An empowering, nonformal education approach for community health workers. Community Development Journal, 23, 117-123.
- Kinebanian, A., & Stomph, M. (1992). Cross-cultural occupational therapy: A critical reflection. American Journal of Occupational Therapy, 46, 751-757.
- King, L.J. (1978). Toward a science of adaptive responses. American Journal of Occupational Therapy, 32, 429-437.
- Kirby, S., & McKenna, K. (1989). Experience, research, social change: Methods from the margins. Toronto: Garamond Press.
- Kittrie, N. (1971). The right to be different: Deviance and enforced therapy. Baltimore: Johns Hopkins University Press.
- Knowles, M.S. (1975). Self-directed learning: A guide for learners and teachers. Chicago: Follett Publishing.
- Kolb, D.A. (1984). Experiential learning. Experience as the source of learning and development. New Jersey: Prentice-Hall.

- Korten, D. (1984). People-centred development: Toward a framework. In D. Korten & R. Klauss (Eds). People-centred development: Contributions toward theory and planning frameworks. West Hartford, CT: Kumarian.
- Krefting, L. (1992). Strategies for the development of occupational therapy in the third world. American Journal of Occupational Therapy, 46, 758-761.
- Kropotkin, P. (1989). Mutual aid: A factor of evolution. Montreal: Black Rose Books.
- Krupa, T., Hayashi, C., Murphy, M., & Thornton, J. (1985). Occupational therapy issues in the treatment of the long-term mentally ill. Canadian Journal of Occupational Therapy, 52, 107-111.
- Krupa, T., Singer, B., & Goering, P. (1988). From hospital to community. Canadian Nurse, 84, 14-16.
- Kuyek, J.N. (1990). Fighting for hope: Organizing to realize our dreams. Montreal: Black Rose Books.
- Labonte, R. (1989a). Community empowerment: The need for political analysis. Canadian Journal of Public Health, 80, 87-88.
- Labonte, R. (1989b). Community and professional empowerment. Canadian Nurse, March, 23-28.
- Labonte, R. (1991). Community health and empowerment: Notes on the new health promotion practice (Unpublished Manuscript).
- Lamoureux, H., Mayer, R., & Panet-Raymond, J. (1989). Community action. Montreal: Black Rose Books.
- Larson, M.S. (1977). The rise of professionalism: A sociological analysis. Berkeley, CA: University of California Press.
- Lasch, C. (1977). Haven in a heartless world: The family besieged. New York: Basic Books.
- Lasch, C. (1984). The minimal self: Psychic survival in troubled times. New York: W.W. Norton.
- Law, M. (1991). Muriel Driver Memorial Lecture: The environment: A focus for occupational therapy. Canadian Journal of Occupational Therapy, 58, 171-180.
- Law, M., Baptiste, S., McColl, M.A., Opzoomer, A., Polatajko, H., & Pollock, N. (1990). The Canadian occupational performance measure: An outcome measure for occupational therapy. Canadian Journal of Occupational Therapy, 57(2), 82-87.
- Leighton, A.H. (1982). Caring for mentally ill people: Psychological and social barriers in historical context. Cambridge: Cambridge University Press.

- Lesemann, F. (1984). Services and circuses: Community and the welfare state. Montreal: Black Rose Books.
- LeVesconte, H.P. (1935). Expanding fields of occupational therapy. Canadian Journal of Occupational Therapy, 3, 4-12.
- Levine, R.E. (1987). Looking back - The influence of the Arts and Crafts Movement on the professional status of occupational therapy. American Journal of Occupational Therapy, 41, 248-254.
- Liberman, R. (1988). Coping with chronic mental disorders: A framework for hope. In R. Liberman. Psychiatric rehabilitation of chronic mental patients. pp. 1-23. Washington, DC: American Psychological Press.
- Lincoln, Y.S. (1992). Fourth generation evaluation, the paradigm revolution and health promotion. Canadian Journal of Public Health, 83(1), S6-S10.
- Lincoln, Y.S., & Guba, E.G. (1985). Naturalistic Enquiry. Newbury Park: Sage Publications.
- Litterst, T.A.E. (1992). Occupational therapy: The role of ideology in the development of a profession for women. American Journal of Occupational Therapy, 46, 20-25.
- Llorens, L.A. (1970). Facilitating growth and development, the promise of occupational therapy. American Journal of Occupational Therapy, 24, 1-9.
- Lord, J., & McKillop-Farlow, D. (1990). A study of personal empowerment: Implications for health promotion. Health Promotion, Fall, 2-8.
- Low, J.F. (1992). The reconstruction aides. American Journal of Occupational Therapy, 46, 38-44.
- Lukes, S. (1974). Power: A radical view. New York: MacMillan Press Limited.
- Lukes, S. (1986). Power. NY: New York University Press.
- MacIntyre, A. (1984). After virtue. 2nd Ed. Notre Dame, IN: University of Notre Dame Press.
- Maguire, P. (1987). Doing participatory research: A feminist approach. Amherst, MA: Center for International Education, University of Massachusetts.
- Manicom, A. (1988). Constituting class relations: The social organization of teachers' work. Ontario Institute of Education, Toronto: Unpublished Doctoral Dissertation.
- Marantz, P.R. (1990). Blaming the victim: The negative consequence of preventive medicine. American Journal of Public Health, 80, 1186-1187.
- Maslow, A.H. (1943). A theory of human motivation. Psychology Review, 50, 370-396.

- Mattingly, C.F. (1991a). What is clinical reasoning? American Journal of Occupational Therapy, 45, 979-986.
- Mattingly, C.F. (1991b). The narrative nature of clinical reasoning. American Journal of Occupational Therapy, 45, 998-1005.
- Maxwell, J.D., & Maxwell, M.P. (1978). Occupational therapy: The diffident profession (Report of the Queen's University Study of Occupational Therapy). Kingston, ON: Queen's University Press.
- Maxwell, J.D., & Maxwell, M.P. (1983). Inner fraternity and outer sorority: Social structure and the professionalization of occupational therapy. in Wipper, A. (ed). The sociology of work: Papers in honour of Oswald Hall. Carleton Library series number 129. Ottawa, ON: Carleton University Press.
- McCullough, S. (1989). Psychiatric research needed to support OT in the community. The National (Newsletter of the Canadian Association of Occupational therapists), 6(3), 12.
- McKnight, J.L. (1989). Health and empowerment. Canadian Journal of Public Health, 76 (supplement 1), 37-38.
- McLelland, D.C. (1975). Power: The inner experience. New York: Irvington Publishers.
- McLeroy, K.R., Gottlieb, N.H., & Burdine, J.N. (1987). The business of health promotion: Ethical issues and professional responsibilities. Health Education Quarterly, 14, 91-109.
- McNeil, M. (1987). Gender and expertise. London: Free Association Books.
- Meyer, A. (1922). The philosophy of occupational therapy. Archives of Occupational Therapy, 1, 1-10.
- Meyers, C. (1992). Among children and their families: Consideration of cultural influences in assessment. American Journal of Occupational Therapy, 46, 737-744.
- Mezirow, J. (1978). Perspective transformation. Adult Education, 27, 100-110.
- Mezirow, J. (1991). Transformative dimensions of adult learning. San Francisco: Jossey-Bass.
- Mezirow, J., & Associates (1990). Fostering critical reflection in adulthood: A guide to transformative and emancipatory learning. San Francisco, CA: Jossey-Bass.
- Miller, J.L. (1990). Creating spaces and finding voices: Teachers collaborating for empowerment. Albany, NY: State University of New York Press.
- Moscovitch, A., & Drover, G. (1981). Inequality: Essays on the political economy of social welfare. Toronto: University of Toronto Press.
- Mosey, A.C. (1970). Three frames of reference for mental health. Thorofare, NJ: Slack.

- Mosey, A.C. (1981). Occupational therapy: Configuration of a profession. New York: Raven Press.
- Navarro, V. (1976). Medicine under capitalism. New York: Prodist.
- Navarro, V. (1978). Class struggle, the state, and medicine: An historical and contemporary analysis of the medical sector in Great Britain. New York: Prodist.
- Navarro, V. (1986). Crisis, health and medicine: A social critique. New York: Tavistock Publications.
- Navarro, V. (1989). Professional dominance or proletarianization?: Neither. The Milbank Quarterly, 66(2), 57-75.
- Ng, R. (1984). Immigrant women and the state: A study of the social organization of knowledge. Unpublished doctoral thesis.
- O'Neill, M. (1992). Community participation in Quebec's health system: A strategy to curtail community empowerment?. International Journal of Health Services, 22, 287-301.
- Panitch, L. (1977). The Canadian state: Political economy and political power. Toronto: University of Toronto Press.
- Peitchinis, S.G. (1989). Women at work: Discrimination and response. Toronto: McClelland & Stewart.
- Peloquin, S.M. (1991). Time as a commodity: Reflections and implications. American Journal of Occupational Therapy, 45, 147-154.
- Peyrot, M. (1982). Caseload management: Choosing suitable clients in a community health clinic agency. Social Problems, 30(2), 157-167.
- Pierce, D., & Frank, G. (1992). A mother's work: Two levels of feminist analysis of family-centered care. American Journal of Occupational Therapy, 46, 972-980.
- Pinderhughes, E.B. (1983). Empowerment for our clients and ourselves. Social Casework: The Journal of Contemporary Social Work, 64, 331-338.
- Pinderhughes, E.B. (1990). Understanding race, ethnicity and power: The key to efficacy in clinical practice. New York: The Free Press.
- Pizzi, M. (1992). Women, HIV infection, and AIDS: Tapestries of life, death, and empowerment. American Journal of Occupational Therapy, 46, 1021-1027.
- Polatajko, H.J. (1992). Muriel Driver Memorial Lecture: Naming and framing occupational therapy: A lecture dedicated to the life of Nancy B. Canadian Journal of Occupational m Therapy, 59, 189-200.

- Primeau, L.A. (1992). A woman's place: Unpaid work in the home. American Journal of Occupational Therapy, 46, 981-988.
- Ralph, D. (1983). Work and madness: The rise of community psychiatry. Montreal: Black Rose Books.
- Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. American Journal of Community Psychology, 15(2), 121-144.
- Readman, T. (1992). Recruitment of men in occupational therapy: Past, present and future. Canadian Journal of Occupational Therapy, 59, 73-77.
- Reed, K.L. (1984). Models of practice in occupational therapy. Baltimore, MA: Williams and Wilkins.
- Reed, K.L., & Sanderson, S. (1980). Concepts in occupational therapy. Baltimore, MA: Williams and Wilkins.
- Reilly, M. (1962). Occupational therapy can be one of the great ideas of 20th century medicine. American Journal of Occupational Therapy, 16, 1-9.
- Reilly, M. (1984). The Issue Is - The importance of the client versus patient issue for occupational therapy. American Journal of Occupational Therapy, 38, 404-406.
- Renwick, R.M., Friedland, J., Sernas, V., & Raybould, K. (1990). Crisis in psychosocial occupational therapy: A closer look. Canadian Journal of Occupational Therapy, 57, 279-284.
- Rinas, J., & Clyne-Jackson, S. (1989). Professional conduct and legal concerns in mental health practice. Norwalk, CON: Appleton and Lange.
- Robinson, I.M. (1981). Muriel Driver memorial lecture 1981: The mists of time. Canadian Journal of Occupational Therapy, 48, 145-152.
- Rogers, C. (1969). Freedom to learn: A view of what education might become. Columbus, OH: C.E. Merrill Publishing Co.
- Rogers, J.C. (1982). Order and disorder in medicine and occupational therapy. American Journal of Occupational Therapy, 36(1), 29-35.
- Rose, S.M., & Black, B.L. (1985). Advocacy and empowerment: Mental health care in the community. Boston: Routledge and Kegan Paul.
- Rosenhan, D.L. (1975). On being sane in insane places. In T.J. Scheff (Ed.). Labelling madness. pp. 54-74. Englewood Cliffs: Prentice-Hall.
- Rothman, D.J. (1980). Conscience and convenience: The asylum and its alternatives in progressive America. Boston: Little Brown.

- Rozovsky, L.E., & Rozovsky, F.A. (1990). The Canadian law of consent and treatment. Scarborough, ON: Butterworths Canada.
- Rozovsky, L.E., & Rozovsky, F.A. (1992). Canadian health information: A legal and risk management guide, 2nd Edition. Markham, ON: Butterworths Canada.
- Rueschmeyer, D. (1986). Power and the division of labour. Illinois: Stanford University Press.
- Ryan, W. (1976). Blaming the victim. NY: Pantheon.
- Scheff, T.J. (1963). The role of the mentally ill and the dynamics of mental disorder: A research framework. Sociometry, 26, 436-453.
- Scheff, T.J. (Ed) (1975). Labelling madness. Englewood Cliffs, NJ: Prentice-Hall. Schutz, A. (1967). The phenomenology of the social world. Translated by George Walsh and Frederick Lehnert. Evanston, Illinois: Northwestern University Press.
- Schon, D. (1983). The reflective practitioner: How professionals think in action. New York: Basic Books.
- Schon, D. (1987). Educating the reflective practitioner: Toward a new design for teaching and learning in the professions. San Francisco, CA: Jossey-Bass Publishers.
- Schutz, A. (1967). The phenomenology of the social world. Translated by George Walsh and Frederick Lehnert. Evanston, Illinois: Northwestern University Press.
- Schwartz, R.K. (1985). Therapy as learning. Dubuque: Kendall Hunt Publishing Company.
- Scott, S.M. (1992). Personal change through participation in social action: A case study of ten social activists. The Canadian Journal for the Study of Adult Education, 6(2), 47-64.
- Sharrott, G.W., & Yerxa, E.J. (1985). The Issue Is - Promises to keep: Implications of the referent 'patient' versus 'client' for those served by occupational therapy. American Journal of Occupational Therapy, 39, 401-405.
- Shepherd, M. (1985). The scientific foundations of psychiatry. New York: Cambridge University.
- Sherwin, S. (1992). No longer patient: Feminist ethics and health care. Philadelphia, PA: Temple University Press.
- Simmons, H.G. (1982). From asylum to welfare. Downsview: National Institute for Mental Retardation.
- Smith, D.E. (1975). The statistics on mental illness (What they will not tell us about women and why). In D.E. Smith & S.J. David (Ed.). Women look at psychiatry. pp. 73-119. Vancouver: Press Gang Publishers.

- Smith, D.E. (1987). The everyday world as problematic: A feminist sociology. Toronto: University of Toronto Press.
- Smith, D.E. (1990a). Texts, facts, and femininity: Exploring the relations of ruling. New York: Routledge.
- Smith, D.E. (1990b). The conceptual practices of power: A feminist sociology of knowledge. Toronto: University of Toronto Press.
- Smith, D.E., & David, S.J. (Ed.) (1975). Women look at psychiatry. Vancouver: Press Gang Publishers.
- Stanley, L. (Ed.) (1990). Feminist praxis: Research, theory and epistemology in feminist sociology. London: Routledge.
- Statistics Canada (1979). Canadian schedule of unit values for occupational therapy. Ottawa: Supply and Services Canada.
- Steinem, G. (1993). A book of self-esteem: Revolution from within. Little, Brown and Company.
- Stewart, M.J. (1991). Preparation for partnership: Reform of professional education. The Canadian Journal for the Study of Adult Education, 5, 1-16.
- Sumsion, T. (1993). Client-centred practice: The true impact. Canadian Journal of Occupational Therapy, 60, 6-8.
- Sutcliffe, J. (1990). Adults with learning difficulties: Education for choice & empowerment. Leicester, UK: The National Institute of Adult Continuing Education.
- Szasz, T. (1961). The myth of mental illness. New York: Hoeber-Harper.
- Tate, S. (1974). The scope for occupational therapists in the community in the future. Canadian Journal of Occupational Therapy, 41(2), 7-9.
- Tough, A. (1979). The adult's learning projects. 2nd Ed. Toronto: The Ontario Institute for Studies in Education.
- Townsend, E. (1987). Strategies for community occupational therapy program development. Canadian Journal of Occupational Therapy, 54(2), 65-70.
- Townsend, E. (1988). Developing community occupational therapy services in Canada. Canadian Journal of Occupational Therapy, 55, 69-74.
- Townsend, E. (1993). Occupational therapy's social vision: 1993 Muriel Driver Memorial Lecture. Canadian Journal of Occupational Therapy, 60, 174-184.

- Townsend-Baglole, E. (1982). Program design, program implementation and counselling: Learning through a self-directed program as an occupational therapist in the field of community mental health. (Unpublished masters thesis)
- Trider, M.F. (1972). The future of occupational therapy. Canadian Journal of Occupational Therapy, 39, 3-8.
- Valentine, M.B., & Capponi, P. (1989). Mental health consumer participation on boards and committees: Barriers and strategies. Canada's Mental Health, 37(2), 8-12.
- Veatch, R.M. (1990). Justice in health care: The contribution of Edmund Pellegrino. The Journal of Medicine and Philosophy, 15, 269-287.
- Waitzkin, H. (1989). A critical theory of medical discourse: Ideology, social control, and the processing of social context in medical encounters. Journal of Health and Social Behaviour, 30, 220-239.
- Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. American Journal of Health Promotion, 6, 197-205.
- Welton, M.(Ed.) (1987). Knowledge for the people: The struggle for adult learning in English-speaking Canada, 1828-1973. Toronto, ON: Ontario Institute for Studies in Education.
- West, W.L. (1984). A reaffirmed philosophy and practice of occupational therapy for the 1980's. American Journal of Occupational Therapy, 38, 15-23.
- West, W.L. (1992). Ten milestone issues in AOTA history. American Journal of Occupational Therapy, 46, 1066-1074.
- Wharf, B. (1979). Community work in Canada. Toronto: McLelland and Stewart.
- Whitmore, E., & Kerans, P. (1988). Participation, empowerment and welfare. Canadian Review of Social Policy, 22, 51-60.
- Wilensky, H.L. (1964). The professionalization of everyone? American Journal of Sociology, 70, 137-158.
- Wolfensberger, W. (1972). Normalization: The principle of normalization in human services. Toronto: National Institute of Mental Retardation.
- Woodside, H. (1984). Community care for the mentally ill. Canadian Journal of Occupational Therapy, 51(4), 182-187.
- Woodside, H. (1991). The participation of mental health consumers in health care issues. National Perspective. Canadian Journal of Occupational Therapy, 58, 3-5.

- World Health Organization. (1984). Health promotion discussion document on the concept and principles. Europe: WHO Regional Office.
- Yerxa, E.J. (1979). The philosophical base of occupational therapy: 2000 AD. Rockville, MD: American Occupational Therapy Association.
- Yerxa, E.J. (1992). Some implications of occupational therapy's history for its epistemology, values, and relation to medicine. American Journal of Occupational Therapy, *46*, 79-83.
- Yerxa, E.J., Clark, F.A., Frank, G., Jackson, J., Parham, D., Pierce, D., Stein, C., & Zemke, R. (1990). An introduction to occupational science: A foundation for occupational therapy in the 21st century. In J.A. Johnson (Ed.). Occupational science: The foundation for new models of practice. New York: Haworth Press.
- Young, I.M. (1987). Difference and policy: Some reflections in the context of new social movements. Cincinnati Law Review, *56*, 535-550.
- Young, I.M. (1990). Justice and the politics of difference. Princeton, NJ: Princeton University Press.
- Zacharakis-Jutz, J. (1988). Post-Freirean adult education: A question of empowerment and power. Adult Education Quarterly, *39*, 41-47.
- Zimmerman, M.A. (1990). Taking aim on empowerment research: On the distinction between individual and psychological conceptions. American Journal of Community Psychology, *18*, 169-177.
- Zimmerman, M.A., & Rappaport, J. (1988). Citizen participation, perceived control, and psychological empowerment. American Journal of Community Psychology, *16*, 725-750.
- Zola, I.K. (1975). In the name of health and illness: On some socio-political consequences of medical influence. Sociology of Science and Medicine, *9*, 83-87.
- Zola, I.K. (1984). Disincentives to independent living: Monograph 1. Kansas: The Research and Training Centre on Independent Living, University of Kansas.