Community Living Division: A Field Practicum Placement

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by

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Abstract

This comprehensive report outlines my field practicum experience with Community Living Division in Prince Albert, Saskatchewan. Over a period of three months, I provided support to persons with intellectual disabilities, accessing resources from the Client Services Unit and Outreach and Prevention Services. Based on my experiences, the concept of ideology will be explored in the context of societal, agency and personal perspectives. The application of critical disability theory and systems theory will be used in the analysis of oppression, as demonstrated within the medical model and group home settings. Additionally, the strategies and skills utilized during the field practicum will be summarized and ethical considerations presented. The report will conclude with a discussion surrounding professional development and implications for future social work practice.
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I would like to conclude this journey by dedicating this report to my late grandmother, Christina MacInnis. The strength you embodied while working as a teacher, pursuing further education and raising a family of eight, continues to act as motivation in the achievement of my goals. I know you would be proud.
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Introduction

Since beginning my career as a social worker, I have had the opportunity to support individuals within a variety of contexts including mental health, addiction and disability. My experiences in these areas served as motivation in pursuing a Master of Social Work degree, at the University of Regina. As professional development remains integral to the field of social work, I was eager to develop new understandings and skills through the direct practice component of this program. Prior to selecting an agency in which to complete a field practicum, I engaged in ongoing reflection surrounding my social location and professional interests. From this, I recognized the significance I attribute to supporting individuals with intellectual disabilities and their families.

At the present time, I am a non-disabled female who had a speech impairment during childhood. I have supported persons with disabilities in a provincial agency as an undergraduate student, in addition to caring for a family member with an intellectual disability. I believe these experiences have significantly contributed to my understanding of disability, while acting as inspiration in my desire to develop skills, as they relate to this area of social work. As such, I completed the field practicum with Community Living Division located in Prince Albert, Saskatchewan, from September 2016 to November 2016.

Field Practicum Agency

Community Living Division is an agency located within the Ministry of Social Services, in the province of Saskatchewan. The agency originated in the year 1972, following a report illuminating the lack of support and discrimination that persons with disabilities were experiencing. As such, Community Living was established to ensure equal access to
governmental services, amongst individuals with disabilities (Ministry of Social Services, 2008, p. 16). At present, this objective continues to serve as the foundation of the services that are provided to individuals, families and service providers in the agency.

In order to access services from within Community Living Division, an individual must demonstrate specific criteria as established by the Ministry of Social Services. These measures include an intelligence quotient (IQ) of seventy or below, impairments in adaptive behaviour and the presence of impairment between the ages of zero and eighteen (Ministry of Social Services, 2008, p. 70). Agency employees make every effort to ensure that those individuals not eligible for services are referred to other organizations more conducive to their needs. Relatedly, referrals to Community Living Division can be made by the individual or a family member, internal agencies such as Child and Family Services and external agencies including schools, hospitals and community-based organizations.

There are a variety of resources available within Community Living Division, based on the unique needs of each individual. Direct support for those residing in supported independent living homes, group homes and approved private-service homes, is provided by the Client Services Unit. Specifically, employees in this area collaborate with residential and vocational service providers to ensure the policies, standards and procedures as put forth by the Ministry of Social Services, are being upheld (Ministry of Social Services, 2008, p. 30). Personal planning meetings, annual reviews and the completion of comprehensive assessments, are examples of the responsibilities held by employees within this unit.

An integral component of this agency involves the support that is provided to individuals with complex behaviours, by the Specialized Programs Unit. Throughout the field practicum, I had the opportunity to work with individuals accessing support from members of Outreach and
Prevention Services, a division of this unit. The tasks held by employees include developing, analyzing and evaluating behavioural intervention strategies, while providing training to service providers as a way to enhance skill development (Ministry of Social Services, 2008, pp. 30-31). Overall, agency staff occupies diverse educational backgrounds and skills, enabling them to work effectively as members of a team.

**Learning Objectives**

Prior to beginning the field practicum, I identified several goals and objectives that would guide my learning as a graduate student, while working with Community Living Division. The development of these goals was primarily informed by my personal and professional experiences, an extensive review of the literature in the area of disability and discussions with agency employees. The goals and objectives were submitted to my graduate program at the University of Regina for approval and would serve as the criteria for the successful completion of the field practicum.

The following are the objectives of the field practicum:

- Develop an understanding of the challenges experienced by persons with disabilities and their families.
- Develop a theoretical understanding of Critical Disability Theory and Systems Theory.
- Develop knowledge and skills relating to completion of intake and comprehensive assessments.
- Develop knowledge and skills relating to collaborative work with community-based organizations in case planning.
- Develop knowledge and skills on rights-based advocacy for individuals with disabilities, while supporting their capacity for self-determination.
Throughout the field practicum, my responsibilities as a student were diverse, as I was fortunate to have supported individuals, families and service providers within various units of the division. This report will explore how disability is understood from varying perspectives, in addition to applying critical disability theory and systems theory, to my experiences supporting an individual in a medical setting and group home environment. Moreover, strategies utilized in the provision of support will be discussed and ethical considerations will be explored. The report will conclude with a summary of learning and aspirations for my career as a social worker. The attainment of each objective will be clearly demonstrated.
Ideology

Understandings of disability have varied considerably throughout history. The meaning attributed to disability is largely determined by dominant ideologies and in effect, influences the ways in which persons with disabilities are treated. Although negative perceptions of disability continue to permeate society, I had the opportunity to participate in the progression of attitudes as they relate to intellectual disability, while working with Community Living Division. This section will begin with an exploration of disability policy throughout history, while examining current societal views and agency perspectives. A discussion surrounding my personal understandings of intellectual disability and the experiences that have influenced these interpretations will follow.

Disability Policy and Societal Perspectives

Throughout my career as a social worker, I have learned that the dominant views as occupied by society, have a profound influence over the meaning that is ascribed to social issues. In the context of disability, Jones, Ouellette-Kuntz, Vilela and Brown (2008) explain that it becomes necessary to examine the attitudes towards inclusivity as held by society, in working towards social change (p. 220). In doing so, we become more cognizant of the challenges experienced by vulnerable populations and our role as social workers in advocating for equality.

Jongbloed (2003) maintains that changing perspectives concerning disability have informed the evolution of policy. Beginning in the early nineteenth century, a law and order approach to disability was adopted, where individuals with disabilities were imprisoned alongside those having committed serious crimes (Jongbloed, 2003, p. 204). It was as a result of this categorization that understandings of disability became equated with deviancy, whereby individuals were isolated from the rest of society and endured harsh punishment. In this way, the
ruling bodies established norms for treatment of individuals with disabilities, directly affecting public perception.

Between the years 1860 and 1890, a small shift in thought resulted in the development of an asylum model of care. This approach was based on the assumption that persons with disabilities were vulnerable and as such, needed protection. However, individuals with physical disabilities were not required to reside in institutions, as they were determined to be less unpredictable than those with intellectual disabilities (Jongbloed, 2003, p. 205). Although this model acknowledges the vulnerability associated with disability, individuals residing in institutions were confined to these spaces, thereby limiting independence and self-determination. At the same time, I believe its implementation was motivated by a need to safeguard society, based on conceptions of disability during this period.

An economic model of disability significantly informed disability policy in the year 1910 and continuing until 1970. This approach centers on an individual’s ability to participate in the workforce, based on their functional capacities (Jongbloed, 2003, p. 205). In the past, if an individual was unable to perform the necessary responsibilities of a particular position, accommodations were rarely made to meet their support needs. At present, persons with disabilities receive public benefits if it is determined that they cannot engage in employment (Jongbloed, 2003, p. 205). However, those individuals with disabilities having contributed to the economic system, in the past, are often viewed as being more deserving of these benefits than those having made no contribution. (Jongbloed, 2003, p. 205). This model reinforces individualism, where contributing to society through the paid labour force affords a sense of belonging to those who are gainfully employed and devalues those who do not.
Similar to the economic approach, the medical model of disability was used to inform policy between the years 1910 and 1970 and continues to influence current understandings of intellectual disability. Within this model, disability is understood as an attribute inherent within an individual, where they come to be viewed as biologically inferior and limited in purpose. A focus is maintained on medical treatment, in order to increase the functional capacity of individuals with disabilities (Jongbloed, 2003, p. 205). Titchkosky and Michalko (2009) further attest that the medical model is premised upon an ideology of normalcy, wherein persons with disabilities are made to seem as ‘normal’ as possible (p. 24). Moreover, disability is constructed as an anomaly to which only certain individuals are subject (p. 47). As disability is framed in this way, it exacerbates the oppression experienced by these individuals and results in exclusionary policies and practices, in the provision of healthcare services.

Beginning in the 1960s, change was realized with the organization of human rights groups throughout Canada. In the context of disability, the independent living movement was established, in addition to five other social movements including civil rights, consumerism, self-help, demedicalization and deinstitutionalization. These movements held similar commitments including consumer sovereignty, self-reliance and political and economic rights (McCrary, 2017, pp. 379-380). The independent living movement represented a dramatic shift in the ways that disability would come to be interpreted by society.

The independent living movement was initially conceived as a response to the construction of disability, inherent in the medical model. Proponents of this new movement argued that the inequality experienced by persons with disabilities, primarily results from limitations in society in responding to their needs, as opposed to individual deficiencies (Bernal & Roca, 2016, p. 82). Essentially, this sociopolitical model redirected attention away from the
intrinsic attributes of the economic and medical model approaches and highlighted the role of the external environment, as contributing to the oppression experienced by individuals with disabilities (Jongbloed, 2003, pp. 205-206).

One of the many significant changes resulting from the establishment of the independent living movement was the view that persons with disabilities are active consumers, as opposed to passive clients or patients requiring care. Individuals with disabilities became empowered to participate actively in all aspects of their lives, while also engaging politically in their communities (Mackelprang & Salsgiver, 1996, p. 10). Furthermore, the movement promoted an analysis of a ‘disabling culture,’ as a way to recognize how societal standards serve to perpetuate discrimination towards persons with disabilities (Bernal & Roca, 2016, p. 82). In doing so, the tenants of previous historical models were challenged, resulting in the development and implementation of policies with the objective of ensuring self-determination.

**Deinstitutionalization.** Jones, Ouellette-Kuntz, Vilela and Brown (2008) maintain that deinstitutionalization has been the most significant shift in the area of disability, resulting in the concept of normalization. Normalization can be defined as “. . . the availability to persons with disabilities, of living circumstances that are as close as possible (physically and socially) to regular patterns in society” (p. 219). The policy of deinstitutionalization was established with notable objectives. Namely, resources from psychiatric institutions were redistributed, with the purpose of providing individuals with increased opportunities to obtain community-based support, while residing with family or caregivers (Sealy, 2012, p. 230). Additionally, the responsibility for providing treatment to individuals with disabilities was assigned to trained clinicians, as opposed to remaining with government representatives (Slate, 2017).
In studies examining individual transitions from psychiatric institutions, Mansell (2006) explains that accessing community-based services provided support that more accurately reflected the needs of consumers (p. 67). However, individuals were being discharged from institutions more rapidly than community-based mental health supports were being established (Sealy & Whitehead, 2004, pp. 249-250). Relatedly, Krieg (2001) maintains that resources for those with more complex needs were deficient, which negatively affected individuals with disabilities and their families, community members, mental health professionals and the criminal justice system among others (p. 368).

As a result of a lack of appropriate supports for individuals being discharged from psychiatric institutions, beliefs inherent in earlier models of disability were reinforced. Slate (2017) explains that as resources were inadequate to support the numbers and specific needs of individuals, many became homeless or incarcerated (p. 347). I believe the understanding of disability as deviance significantly shaped the ways in which society responded to deinstitutionalization. However, this policy made a meaningful impact in defining self-determination, in addition to the evolution of how disability is understood and in effect, how persons with disabilities should be treated.

**Community Living Division**

While completing the field practicum with Community Living Division, I gained awareness surrounding best practices in the context of disability, while learning of the significance attributed to the values of inclusivity, equality and self-determination. The actions of employees, management and service providers in upholding these values in their work was notable and demonstrated the progression of the agency in challenging societal norms. These
practices are reflective of the standards upheld in the governing policy of Community Living Division, known as the Comprehensive Personal Planning and Support Policy.

The Comprehensive Personal Planning and Support Policy comprises ethical guidelines that are used to inform service provision, when supporting persons with disabilities in Saskatchewan (Ministry of Social Services, 2009, p. 20). The principles outlined in the policy were developed with the understanding that regardless of disability, every individual should be provided with choices surrounding how they want to live their lives (Ministry of Social Services, 2009, p. 23). As training is provided on an ongoing basis, it is assumed that the actions of employees, management and service providers within the agency, accurately reflect the standards as proposed within this policy.

A critical component of this document that underlies the responsibilities of employees within Community Living Division, is supported decision-making. According to Bodnar (2001), this process involves “. . . acting with an individual to discover their values, interests, talents and gifts in order to support them to choose the way they want to live their life” (as cited in Ministry of Social Services, 2009, p. 58). In the past, having a disability meant that the individual had little to no choice in making decisions about their lives. However, the Ministry of Social Services (2009) maintains that the individual now plays an active role in the decision-making process, primarily as it relates to their well-being and is supported by those who are trusted by the participant (p. 59).

Based on my experiences, supporting a decision having negative consequences can be difficult as a service provider, as there is often an initial reaction of wanting to protect the individual from possible harm. However, just as non-disabled individuals are afforded opportunities to make decisions having consequences, so too should individuals with disabilities.
Employees and service providers within Community Living Division attest to the significance of discussing matters relating to a decision, while also reassuring the individual that they will be there to support them no matter what the outcome. This ultimately contributes to the development of trust within the helping relationship and illustrates the importance attributed to self-determination by the agency.

Another practice that is upheld by Community Living Division and described within the Comprehensive Personal Planning and Support Policy, is the application of a person-centred approach to practice. Taylor and Taylor (2013) explain that the significance attributed to this approach primarily resulted from the deinstitutionalization movement, where understandings of disability began to shift. Specifically, importance was relocated to individualized support plans and away from formal treatment interventions, as predominant responses to disability (p. 214).

Person-centred planning is described by the Ministry of Social Services (2009) as maintaining a focus on the goals and aspirations of participants. As examples, the strengths, lifestyle preferences and cultural background of each individual are actively explored with family, friends, caregivers and others who are familiar with the participant (p. 78). Taylor and Taylor (2013) attest that the planning process should be collaborative and ongoing, with a commitment made by the group to support the achievement of the goals (p. 218). The objective of this approach is to ensure that individual programming and the provision of support by caregivers and service providers, is reflective of the unique needs of each individual. The significance of person-centred planning within the agency, illustrates a clear deviation from historical approaches of supporting individuals with disabilities.

Overall, my experiences supporting individuals, caregivers and service providers, contributed to an increased sense of awareness relating to best practices and values in the area of
intellectual disability. Additionally, my learning was enhanced through reflecting upon my personal values and the significance of these beliefs within my practice as a social worker. It is through these understandings that I have become more cognizant of the ways in which my past experiences have shaped my personal values and more specifically, the meaning I attribute to disability.

**Personal Views and Intellectual Disability**

Similar to the standards occupied by Community Living Division, I value inclusivity and self-determination, while adopting a person-centred and strengths-based approach in my work with vulnerable populations. In reflecting upon my personal values, I have learned that my professional experience working within the medical model and my role supporting a family member with an intellectual disability, have significantly informed my understanding of the oppression affecting individuals with disabilities.

While residing in Nova Scotia, I was working within an agency supporting individuals with mental health and addiction-related concerns. My role was comprised of various responsibilities including completing comprehensive assessments and formulating recovery plans, based on the participant’s goals for treatment. As the majority of these tasks were conducted in a hospital setting, the medical model primarily informed the responsibilities held by employees within this agency. From this experience, I observed the difficulty individuals faced in accessing treatment, directly resulting from perceived discrimination of hospital staff. I learned that the stigma surrounding mental health, addiction and disability, was being perpetuated by a system that is premised upon ensuring the well-being of all Canadians.

In addition to becoming aware of oppressive practices of healthcare staff towards individuals with disabilities, I learned how the medicalization of language can impact the
construction of this social issue. As a direct result of the medical model framework that guided my work, I came to understand disability as a word describing physical or intellectual variances and utilized the word according to this interpretation. However, upon researching disability theory at the outset of the field practicum, I learned of the distinction between disability and impairment, as illustrated by Michael Oliver (1998). He provides the following definition:

Impairment is the functional limitation within the individual caused by the physical, mental or sensory impairment; disability is the loss or limitation of opportunities to take part in the normal life of the community, on an equal level with others because of physical and social barriers. (p. 1447)

As these terms are often used interchangeably in the provision of services throughout society, it becomes necessary to differentiate between them. In doing so, disability is illuminated as a socially constructed concept, where focus can be redirected towards the barriers experienced by persons with disabilities, while challenging positivist conceptions of disability that perpetuate discrimination.

Another significant aspect of my life that has influenced my perception of disability, is the support I provide as a family member, to my aunt who has an intellectual disability. Based on my relationship with her, I have adopted an overprotective attitude in regards to her overall health and well-being. Specifically, I would advocate to limit her engagement in activities with harmful outcomes. I assumed that as she would be vulnerable in certain situations, and that steps should be taken to protect her when possible. This belief was therefore transferred from my personal experience, to my work with Community Living Division.

After attending a training session surrounding the Comprehensive Personal Planning and Support Policy, I learned that the actions associated with my attitude were limiting my aunt’s
self-determination. Similar to the belief as advocated by Community Living Division, I realized that regardless of her disability, my aunt has the right to make decisions where the outcome remains questionable. Essentially, supporting an individual in their decisions coincides with upholding their right to make choices about their life. This awareness not only informed my practice as a student, but has also transformed the ways in which I support my aunt.

“Our ways of knowing organize ways of being. . .” (Titchkosky, 2007, p. 102). This statement encapsulates the essence of ideology, in that understandings of disability as influenced by societal interpretations, personal experiences and other factors, ultimately determines how persons with disabilities are treated. I believe that becoming aware of our own thoughts and beliefs is fundamental in shifting our interpretations and subsequent responses to disability. It is only then that we have the opportunity to truly listen, learn and contribute to the evolution of meaning, in the context of disability.
Theory

The application of two theoretical approaches informed the analysis of my practicum experiences with Community Living Division. Based on a review of the literature in the area of disability, critical disability theory and systems theory were used in the exploration of my experiences throughout the field practicum. These theories illuminated the predominant constructions of disability and subsequently, increased my awareness of the oppression faced by individuals with intellectual disabilities. This section will begin with an examination of each theoretical approach, followed by a case study illustrating the oppression contained within the medical model and group home settings.

Critical Disability Theory

The application of a critical perspective provides the opportunity to examine discrimination originating in prevailing attitudes, policies and systems as a whole (Prince, 2009, p. 10). I anticipated that in adopting a critical theoretical approach, I would become cognizant of the challenges experienced by persons with disabilities and more specifically, my role as a social worker in the provision of support. Moreover, I decided that utilizing a theory recognizing the sociopolitical nature of disability was necessary, given the emphasis on promoting equality within Community Living Division.

Critical disability theory deconstructs the values and norms inherent within neoliberalism, as they relate to disability (Hosking, 2008, p. 5). Prince (2009) describes neoliberalism as an ideology that significantly influences social policy and questions the role of the welfare state in the provision of social services to Canadians. Social programs are therefore viewed as impeding freedom and creating dependency on government supports (p. 186). As
such, individual responsibility is upheld as a significant component within the neo-liberal ideology.

Within the context of neo-liberalism and the welfare state, responsibility for social provision lies with the local community, the individual and their families. The role of the government is significantly reduced, public services are diminished and the involvement of charitable groups increases (Prince, 2009, pp. 186-187). Moreover, Rioux and Valentine (2006) attest that the interpretation of disability as an individual pathology is adopted by various governmental agencies, based on the presence of neo-liberalism within Canadian society (p. 51).

In a study examining the attitudes of Canadians toward disability, Prince (2009) reported that participants indicated that persons with disabilities, and their families, should be primarily responsible for all matters relating to provision of support (p. 7). The results of this particular study are a reflection of neo-liberal thought and current societal attitudes relating to disability. Furthermore, Krogh and Johnson (2006) indicate that because of the predominance of neo-liberalism, there has been a reduction in the availability of disability supports, variations in the provision of services and an overall decrease in life opportunities to those individuals accessing services (p. 153). I believe such directives can be equated to forms of punishment and although they differ from the mistreatment endured by persons with disabilities throughout history, the meaning attributed to disability remains markedly similar.

Prior to the industrial period, persons with disabilities were not characterized as belonging to a particular group, in contrast to the categorization that typifies Canadian society today. Instead, they formed a part of a larger group comprising those individuals living in poverty. With the rise of capitalism, individuals were then classified according to those who were willing but unable to work and those who were not willing to work (Michailakis, 2003, p.
The value of an individual was directly related to the contribution they could make to the economy. At present, similar beliefs remain prevalent in discussions surrounding citizenship.

Prince (2009) describes persons with disabilities as absent citizens, resulting from their experiences of oppression within social structures. This can be illustrated in the high rates of poverty and unemployment felt by individuals with disabilities currently (p. 3). Although the Canadian government asserts that gaining employment remains critical in the attainment of citizenship status, individuals with disabilities continue to experience difficulty participating in the labour market (Titchkosky, 2007, pp. 167-168). Therefore, if an individual cannot contribute to society in this way, it is believed they are not worthy of full citizenship.

Relatedly, Devlin and Pothier (2006) explain that productivity can be viewed as an ableist discourse, originating in neo-liberal thought that only furthers the discrimination experienced by persons with disabilities. They assert that citizenship needs to be redefined outside of expectations surrounding productivity and efficiency (p. 18). Additionally, Prince (2009) attests that the meaning of citizenship should account for the impact of social factors, within the lives of persons with disabilities (p. 3). I believe that a reconceptualization of the meaning ascribed to Canadian citizenship will be fundamental in transforming current societal views, while creating a more holistic understanding of disability and inclusivity within our communities.

In the context of disability, normalcy is privileged over abnormalcy and disability is often characterized as a personal misfortune within the ideological principles of neo-liberalism (Devlin & Pothier, 2006, pp. 10-11). This concept of normality would gain precedence during the industrial era, where white, able-bodied, heterosexual males were determined to be the standard of which to compare all others. Individuals not meeting this standard were assumed to be inferior and treated accordingly. It was during this historical period that difference would become
redefined as deviance (Michigan Disability Rights Coalition, n.d., para. 29). This interpretation of disability would negatively affect the ways in which the behaviours of individuals with disabilities were interpreted and subsequently treated.

As the emphasis remained on productivity in the advent of the industrial era, scientific knowledge was being used to inform various aspects of life, including understandings of disability. It was at this time disability became medicalized, resulting in limitations to self-determination (Prince, 2009, p. 82). Specifically, Titchkosky (2007) explains that disability was viewed as an attribute inherent within an individual, unrelated to environmental factors (pp. 187-188). Disability came to be associated as an abnormal condition that should be treated as such (p. 91). In this way, treatment would reduce the impact of the disability, thereby bringing the individual closer to the societal ideal of normality.

The eugenics movement operated on an understanding of normality. Leung (2012) explains that eugenics encompassed several components including institutionalization, the reproduction of individuals occupying particular traits deemed superior, and physical sterilization as a way to prevent certain individuals from having children (para. 3). Individuals with disabilities were subjected to horrific procedures, as they were believed to be unpredictable in behaviour and vulnerable (Savell, 2004, p. 1093). It is apparent that historical understandings of disability significantly informed the eugenics movement.

Critical disability theory illustrates the impact of neo-liberalism on the meaning attributed to disability and its application to current governmental practices. Based on utilizing this theoretical approach to inform my field practicum experiences, I believe I have become more mindful of how structuralism influences vulnerable populations and I have developed a better
understanding of the origins of the oppression experienced by individuals with disabilities, throughout history.

**Systems Theory**

Based on my experiences during my career as a social worker, I have learned that individuals access support from a multitude of systems. In the context of my work within Community Living Division, participants utilize services from internal and external agencies in the surrounding communities. As such, I decided that the application of a systems theoretical approach to the field practicum would be integral, in analyzing the experiences of persons with intellectual disabilities, within a variety of social systems.

Michailakis and Schirmer (2014) explain that there are multiple systems contained within society that serve a function, including systems of medicine, politics and religion among others. Observations are made from within each system’s perspective and a solution is provided in relation to a particular societal problem. However, it is only the values reflected within this system that inform the perspective of the observers (pp. 433-434). Therefore, illustrating the differences that exist between systems becomes essential in demonstrating how the meaning of disability can vary significantly within different systems in society.

When providing support to persons with disabilities, Swango-Wilson (2010) attests that it is necessary to understand the systems directly affecting their lives, as a way to ensure their needs are being met (p. 160). She explains that the four primary systems of which individuals become affiliated include the family, state, voluntary organizations and business establishments (p. 161). Notably, the values and expectations inherent within these systems largely influence what can be achieved by the individual (p. 163). Ultimately, systems theory illuminates the interrelations between individuals, families, institutions and societies (Flamand, 2017, para. 4).
The meaning that comes to be associated with disability is influenced by the perspective of the systems from which it is observed (Michailakis, 2003, p. 220). This aspect of systems theory illuminates the challenges that persons with disabilities endure, in accessing services from within different systems. Although I believe that membership in a system strongly influences the perspective of the observer, it is important to explore the values and experiences embodied by the individual outside of the system to gain a more holistic understanding of the societal issue.

Prior to beginning the field practicum, I could not have predicted the variability in understanding existing amongst systems surrounding intellectual disability. My experiences allowed for an increased sense of awareness relating to the discrimination that persons with disabilities experience when accessing support, in addition to the necessity of forming partnerships with systems, as a way to ameliorate the provision of services to this population. It is in recognizing the power embodied by systems, in the determination of how persons with disabilities are treated, that change can be realized.

As a way to further my understanding, I engaged in ongoing reflection relating to the responsibilities I held in supporting individuals with disabilities, while working with Community Living Division. From this, I developed insight into the meaning attributed to disability within the medical system in particular and learned how my analyses were reflective of the values from the government agency in which I was working. Reflection was a fundamental aspect of my learning during this time, as it enabled me to think more critically about systemic influences and the significance of collaboration between systems.

**Connecting Theory to Practice**

I had the opportunity to work with a male participant accessing services through Community Living Division, who will be referred to as Paul for the purposes of this report. Paul
was residing in a group home when we initially met and I followed his transition from this setting to a mental health unit in the province, where he was admitted until another residential placement could be secured. Throughout this section of the report, I will explore my interpretations of his experiences in these environments, specifically highlighting the differences between each system.

**Case study.** Paul is a thirty-two-year-old male and was diagnosed with an intellectual disability in childhood. He is verbal and communicates in the English language and has an understanding of Cree. When responding to questions, Paul will usually reply in twenty seconds, to allow time for processing the information received. Paul is independent in most areas of daily living, but may need reminders to consume a healthy and balanced diet, in addition to engaging in proper hygiene including bathing, washing hands and brushing his teeth. Paul enjoys playing sports, namely baseball and soccer, in addition to spending time outdoors.

Paul has been residing in a group home for the last two years since his aging father was no longer able to care for him. Although his father and older brother reside in Saskatchewan, the group home located in that community is not accepting new residents, as they are currently at capacity. As a result, Paul was residing in a group home approximately three hours away from family, with two male residents. However, it became apparent that this particular setting was not conducive to Paul’s support needs and another placement had to be secured by Community Living Division. Until that time, it was determined by Paul, his family and the service providers that he would reside in a mental health unit at a local hospital.

**Disability and the medical model.** “Disability is a difference that is not supposed to make a difference” (Titchkosky, 2007, p. 125). This statement captures the meaning attributed to disability from a medical perspective, whereby persons with disabilities are understood as being
in need of treatment to reduce the impact of the disability, as opposed to being viewed as contributing members of society. Prince (2009) explains that when interpretations of impairment became medicalized during the industrial era, this resulted in health profession dominance, inspired the segregation of persons with disabilities, and limited self-determination (p. 82). This notion of impairment embraced by the medical model continues to inform the practices of employees within the healthcare system, in the provision of support to individuals with disabilities.

While Paul was admitted to the hospital, it was the responsibility of Outreach and Prevention Services within Community Living Division to ensure he was adjusting to the transition from his residential placement. During this time, I observed the differences in policies between Community Living Division and the mental health unit where Paul was residing. In my opinion, the environment was very similar to an institution and it appeared that patients admitted to this particular unit, had little choice in making decisions relating to their daily activities.

One of the inherent differences between the practices of each system, surrounds the meaning that is ascribed to intellectual disability. Similar to historical constructions of disability, Titchkosky (2007) explains that medicine “. . . locates the source of trouble as well as the place of treatment primarily in individuals and makes the etiology of the trouble asocial and impersonal” (p. 86). I observed actions reflective of this interpretation amongst healthcare professionals while supporting Paul in the medical setting. Specifically, hospital staff reported that Paul was engaging in challenging behaviours, including intentional incontinence and refusing to shower. These behaviours came to be interpreted as deviant actions, where Paul was believed to be the problem.
Every service provider that receives funding from Community Living Division is required to report challenging and aggressive behaviours to agency caseworkers. If these actions remain consistent, Outreach and Prevention Services will work collaboratively with service providers in observing the behaviour(s) and providing recommendations based on the resulting data. As described by the Ministry of Social Services (2009), every behaviour has a function and the occurrence of particular behaviours is often a form of communication (p. 95). It therefore becomes critical, as a service provider, to remain cognizant of the significance of behaviours that may otherwise be perceived as defiance.

Although the medical team informed Outreach and Prevention Services of Paul’s reoccurring behaviours, they were not obligated to track these behaviours as an external organization. This made it difficult for Community Living Division to interpret what Paul was attempting to communicate. Nevertheless, agency employees utilized the information they received encompassing the antecedents and consequences to the behaviours and developed strategies for implementation in order to reduce the impact of these behaviours. Unfortunately, consistency was not maintained with the implementation of these approaches, given the numerous responsibilities occupied by medical staff. As a result, the behaviours endured and Paul lost privileges, as his actions were equated with purposeful disobedience.

Titchkosky (2007) explains that the medical system assumes responsibility in describing disability, how it comes to affect individuals, and the ways in which to prevent or treat the impairment. From this perspective, disability is therefore constructed as a loss (p. 134). Persons with disabilities come to be compared to the standard of normalcy as maintained within this system, a non-disabled individual. Titchkosky and Michalko (2009) attest that the medical system has been established on this ideology of normalcy, where it is anticipated that persons
with disabilities should strive to achieve this standard in order to better their lives (p. 7). As Paul’s behaviours came to be understood as rebellious by the medical team, this provided justification for the consequences Paul experienced, with the anticipation that this would alleviate his engagement in the challenging behaviours.

In my professional experience, I have observed that establishing consequences is assumed to reduce the presence of challenging behaviours. Relatedly, this was the justification used by the medical team in response to his actions. Specifically, Paul lost his privileges to smoke and was not permitted to leave the mental health unit for community outings. Moreover, he was placed in restraints on several occasions. Not surprisingly, the application of these measures of forced adaptation were not successful in eliminating the challenging behaviours and alternatively, contributed to their prevalence.

The utilization of consequences varies significantly between the medical system and Community Living Division. The Ministry of Social Services (2009) maintains that using consequences as a means to reduce challenging behaviours, is a violation of an individual’s human rights and can have a negative impact on the helping relationship (p. 48). A planned consequence inflicted by a service provider on a participant is referred to as an aversive procedure by the agency and is not used when supporting individuals with disabilities (pp. 45-46). These practices were common historically and, unfortunately, continue to be used within the medical system as a response to disability. As such, it becomes especially difficult to implement behavioural supports within a system occupying conflicting beliefs and practices from another agency.

After learning that Paul was being placed in restraints, I became concerned with his emotional reactions stemming from these incidents. In a study conducted by Wilkins (2012), the
emotional impact of physical restraints on individuals with disabilities is explored. Participants in this study reported feeling ashamed, as well as feeling fearful of the possibility of being restrained in the future. Moreover, the author indicates that the experience of being restrained has the potential to elicit traumatic memories for the individual (p. 132). Consequently, the inappropriate and consistent use of physical restraints by professionals, can contribute to the normalization of this response to challenging behaviours.

In reflecting on Paul’s experiences, there is a need to examine healthcare practices in supporting persons with disabilities across systems. Weiss and Lunsky (2010) have studied the utilization patterns of persons with intellectual disabilities, to determine the efficacy of healthcare services. Participants reported that services should be provided based on the needs of each individual. However, they indicated that non-specialized healthcare settings are not prepared to provide this support (p. 155). As such, participants emphasized the significance of organizing training opportunities amongst physicians, psychiatrists, nurses and social workers, to increase capacities within this area (p. 156). Ultimately, increasing collaboration between systems in the Province of Saskatchewan will significantly reduce the discrimination experienced by persons with disabilities accessing services at present.

Although disability is primarily recognized as a biological condition within the medical model, an evolution of understanding disability remains possible as multiple systems work collectively in the provision of support. I believe that opportunities to learn from within each system will enrich the quality of services available to persons with disabilities, while also enhancing the accessibility of these resources for individuals and their families. This, in turn, will create more awareness surrounding inclusivity and the importance of self-determination.
**Group homes and the perpetuation of oppression.** Saskatchewan was the first province in Canada to initiate deinstitutionalization within psychiatric hospitals, where individuals with disabilities were relocated to residential settings (Sealy & Whitehead, 2004, p. 256). It was anticipated that this transition would allow for increased opportunities for choice, involvement in leisure activities, and more favourable interactions with residents and service providers (McConkey et al., 2016, p. 110). Group homes were therefore developed as an alternative to the restrictive establishments used to segregate persons with disabilities throughout history. More recently however, these homes and their subsequent policies are being likened to institutional practices.

A group home is defined by Clement and Bigby (2010) as an “. . . accommodation for between four and six people, where extensive or pervasive paid staff support is provided to the residents, both in the home and when leaving it to use community-based settings” (p. 15). The authors explain that placement within residential settings is largely determined by the severity of the impairment and that individuals themselves are not always provided with a choice as to where they wish to live (p. 28). Similarly, attempts to place individuals in their home communities in Saskatchewan or a specified location of their choosing, is a priority within Community Living Division. Unfortunately, this cannot always be guaranteed due to the increasing numbers of individuals requesting services from the agency.

Group home settings are described in the literature as encompassing an organizational culture. In a qualitative study, Bigby, Knox, Beadle-Brown, Clement and Mansell (2012) examine the role of culture in the provision of support to residents within group homes. The findings indicate that staff members would refer to residents as children or by a health condition, while also asserting that they lacked the necessary skills to contribute to society (pp. 457-458).
Employees also reported that they maintained a strict routine for all residents within the home (pp. 460-461). These actions are examples of discrimination that would not be anticipated in a group home, an environment where values including self-determination and equality should be observed. Their behaviours are reflective of predominant ideologies relating to disability, impeding the quality of care afforded to group home residents.

The results of this study are consistent with Paul’s experiences while residing in a group home. Initially, transitioning to the group home was difficult for Paul, as he was adjusting to a new environment and routine, as well as living away from his father. Within a few months, Paul was feeling more comfortable in his new home, as demonstrated through the development of friendships with the other residents. However, Community Living Division began receiving incident reports from the service provider approximately one year after his transition to the group home. Paul was described to have engaged in intimidation and verbal aggression towards staff, in addition to eloping from the property on several occasions. Based on this information, Outreach and Prevention Services began working with group home employees to initiate the collection of data relating to the occurrence of these behaviours.

In examining the information yielded in the reports, a pattern was noted in the descriptions of specific incidents involving Paul. His actions including refusing to shower, incontinence and not listening to the demands of group home employees, was predominantly attributed to deviancy. Upon further analysis of the data, the agency learned that little choice was being provided to Paul in decisions affecting his life. Moreover, group home staff impeded his participation in favorable activities, as a way to reduce his behaviours through the use of consequences. As such, it should not be surprising that he was not adhering to their requests. I believe the actions of the group home employees were attempts to eliminate the deviant
behaviours, as informed by standards of normalcy. However, ableist norms should not predicate treatment towards persons with disabilities, particularly within a group home setting.

A critical component of the responsibilities held by employees within Community Living Division surrounds the provision of support to service providers. In this situation, the agency actively engaged with group home employees in order to develop a collective understanding as to the function of Paul’s behaviours. Specifically, group home staff were asked to track Paul’s behaviours in order to determine what he was communicating. After reviewing the data, members of Outreach and Prevention Services developed recommendations as a way to reduce the impact of each behaviour on Paul, in addition to ameliorating communication between Paul and group home employees.

Although the service provider was receptive to the suggestions provided by Community Living Division, the strategies were not implemented using a consistent approach. In the study conducted by Bigby et al. (2012), participants interpreted attempts by the larger organization in building capacity, through the development of new skills and implementation of new objectives, as challenging their abilities as professionals. As such, many staff explained that they resisted change (p. 461). Relatedly, it’s possible that group home employees were also experiencing some hesitation surrounding the implementation of new practices regarding Paul’s behavioural supports. It was therefore determined that a transition out of this group home was necessitated for Paul, as a way to ameliorate his quality of life.

It is anticipated that in the upcoming years, there will be a shift amongst individuals accessing services from agencies such as Community Living Division. More specifically, McConkey et al. (2016) explain that emphasis is being redirected towards independent housing options, in keeping with the value of self-determination. This will provide the opportunity for an
individual to rent or own a property, while receiving support appropriate to their needs (p. 110). With this transition from group to independent living, an increase in numbers of individuals with higher support needs will be requesting residential placements (Bigby, Knox, Beadle-Brown & Clement, 2015, p. 283). However, as it remains difficult to secure placements in desired residential settings at present, higher demands will likely have a detrimental impact on the availability of supports for individuals and their families.

Shipton and Lashewicz (2016) further attest to the problems experienced by coordinators, when exploring possible placements for individuals with complex behaviours, particularly within rural communities (pp. 9-10). This finding is especially relevant to the complexity involved in securing an appropriate placement for Paul. A factor impeding this process was the limited number of beds available within residential settings, in addition to the attitudes occupied by service providers in providing support to an individual with behavioural needs. As a result of reports from his previous group home, I observed that potential placement homes were less likely to consider Paul when an opening became available. It seems that although equality is purported as an integral component by residential agencies, discrimination based on the severity of the disability significantly impacted the accessibility of a possible placement.

Overall, based on tenants within the independent living model, building staff capacity in residential agencies is fundamental in the development of positive relationships between service providers and participants. As a result of my research and learning stemming from Paul’s experiences, I believe that group homes have the potential to replicate institutional settings, if policies and practices are not consistently reviewed. At the same time however, I have also witnessed the benefits associated with residing in a group home setting, where the environment is reflective of a home and where the needs of each resident are met and respected by employees.
Strategies

At the outset of the field practicum, I shadowed several employees working in different areas of Community Living Division, in order to become familiar with the resources and tools utilized by the agency in supporting persons with intellectual disabilities. As the practicum progressed, I developed specific skills relating to these resources, primarily through direct practice with individuals, families and service providers. This section of the report will explore the strategies employed by the agency, including counselling, assessments and comprehensive behaviour supports, while drawing on my experiences in the application of these resources.

Counselling and Assessments

As with most agencies providing support to vulnerable populations, counselling is an essential responsibility held by employees within Community Living Division. Depending upon the identified concerns of the individual, family or service provider, the agency plays an active role in the exploration of potential solutions. Oftentimes, support is provided to the individual by the service provider and if the need for more formal advising is warranted, Community Living Division would become involved. Moreover, if any concerns arise pertaining to a diagnosis or prescribed medications, contact with a physician or psychiatrist would be initiated.

The completion of comprehensive assessments is a primary task held by employees, within the various units comprising the agency. I observed that this process would often encourage participants to discuss challenges, stressors and associated emotions, resulting in counselling. Specifically, I engaged in counselling during assessments regarding establishing relationships, maintaining boundaries and conflict management among other topics. These opportunities furthered my counselling skills as a social worker, particularly in the areas of building rapport, active listening and developing appropriate goals.
There are several assessments that are employed by Community Living Division in determining support needs, behavioural supports or financial eligibility for services. The Daily Living Support Assessment (DLSA) is a tool that is used to establish the level of support and funding an individual requires (Ministry of Social Services, 2014, p. 4). The Daily Living Support Assessment explores independence in the areas of dependence, behaviour, health and independent living skills. This includes determining needs in the areas of bathing, social awareness, medications and food preparation among many others (D. Reddekopp, personal communication, Oct. 5, 2016). When administering this assessment, I learned that providing specific examples of each area to families and service providers elicits more detailed information reflecting the unique needs of the participant.

In addition to supporting persons with intellectual disabilities, Community Living Division also works closely with families having a child with an intellectual disability. The agency recognizes the importance of acknowledging the challenges the family unit can experience, which is actively explored throughout the Family Impact of Disability Assessment (FIDA). This assessment determines whether a family qualifies for an income-tested respite benefit available through Community Living Division. The Ministry of Social Services (2016) describes respite as a temporary break for the parents of a child with an intellectual disability, which can allow for opportunities to ameliorate their personal health and well-being (para. 3). As such, this financial benefit can assist families with the costs associated with arranging for the care of their child, outside of the home.

I had the opportunity to complete this assessment with a member of the Client Services Unit, while supporting families throughout the field practicum. I observed that the majority of caregivers reported similar themes in regards to caring for their child with an intellectual
disability. Specifically, they expressed the difficulties they experience with the completion of daily responsibilities, the effects on other children in the home, and the strain within the marital relationship. Additionally, caregivers reported that they often felt a sense of guilt in response to focusing on anything other than their child. As such, internalizing feelings was frequently indicated as a coping mechanism.

Overall, I believe that the Family Impact of Disability Assessment is a tool essential to the provision of support to families within the agency. It is an assessment that shifts the focus to caregivers, in an effort to recognize their challenges, while encouraging discussion surrounding the resulting emotions. In my opinion, however, the allocation of funding is not reflective of the difficulties experienced by families supporting a child with an intellectual disability, particularly amongst those residing in rural Saskatchewan. These families face increased barriers as a result of their geographic location, including traveling longer distances to medical appointments due to a lack of specialized resources in the home community and fewer social supports. Ultimately, this is illustrative of the impact of neo-liberalism, in that the family unit is held primarily responsible in the provision of support, with minimal government involvement or assistance.

**Comprehensive Behaviour Support**

One of the most significant learning experiences occurring throughout this field practicum, was the opportunity to work with members of Outreach and Prevention Services in supporting individuals with complex behaviours. Prior to beginning the practicum, I had minimal knowledge relating to the development and implementation of specific behavioural supports, in the context of intellectual disability. During the field practicum, I became familiar with a variety of strategies and approaches that are utilized in reducing the impact of a challenging behaviour,
while furthering my skills as a social worker through collaborative work with participants and their caregivers.

Comprehensive Behaviour Support (CBS) is a holistic approach that is utilized in the presence of behaviours considered challenging, dangerous, or harmful to the individual or others. Challenging behaviours can be described as disruptive or offensive, but are not threatening. These can include yelling, wandering and ignoring requests. In contrast, dangerous behaviours are actions that harm the individual, others, or animals; and can include hitting, pulling hair or running in traffic (Ministry of Social Services, 2009, pp. 94-95). It is essential to differentiate between each type of behaviour, as I have observed instances where actions were misinterpreted as more threatening than what were intended.

The Ministry of Social Services (2009) maintains that each behaviour has a meaning and, as service providers supporting individuals with disabilities, we need to respond in a manner that promotes trust and safety. Ideally, the individual should feel encouraged to express their needs, as opposed to internalizing what they are experiencing (p. 95). As a way to support the individual and their needs, Comprehensive Behaviour Support can be utilized to alter the impact of the behaviour, as opposed to eliminating the behaviour entirely (p. 96). I believe that the elimination of the challenging behaviour can be an initial reaction of caregivers. The correlation between deviancy and disability is demonstrated here, in that the presence of challenging behaviours has become equated with malevolence and therefore worthy of consequences. In effect, ideological assumptions are used to inform responses to the behaviour.

Contrary to the use of punishment that prevailed as a response to challenging behaviours throughout history, the Ministry of Social Services (2009) attests that Comprehensive Behaviour Support employs only positive strategies (p. 96). These strategies include ecological changes,
positive programming, focused support and reactive strategies (p. 100). A Comprehensive Behaviour Support Plan (CBSP) containing these strategies is only developed when behaviours are challenging, dangerous or harmful; in addition to when the participant requests assistance with specified behaviours (p. 99). A Comprehensive Behaviour Support Plan was developed for Paul, by members of Outreach and Prevention Services. The strategies were primarily informed by data collection and the analysis of the challenging behaviours, while he was residing in the group home setting.

Ecological changes are described by the Ministry of Social Services (2009) as alterations that occur within the immediate physical environment, including noise level, lighting and room size (pp. 100-101). Similar recommendations were made in response to the agitation Paul was experiencing in the group home. Specifically, the number of individuals in Paul’s space was reduced when he was showing signs of distress, as a way to avoid escalation and ensure the safety of the others in the home. Additionally, group home staff was encouraged to change the ways in which they communicated instructions to Paul, as he would often become irritated when demands were made of him. As an example, instead of telling Paul to complete his chores at a certain time, providing him with the choice of beginning his responsibilities in the morning or afternoon was less likely to result in conflict.

Positive programming is another strategy that is used often when supporting persons with intellectual disabilities, where the individual is provided with alternatives to the challenging behaviour. It is anticipated that new skills are developed, resulting in positive forms of communication (Ministry of Social Services, 2009, p. 101). This strategy was also applied to Paul’s behaviours. As an example, Paul would often hug strangers in public settings or would hug individuals whom he had just recently met. In order to engage in a more socially appropriate
behaviour, Paul was encouraged to shake hands upon meeting someone and ask permission prior to hugging someone with whom he is familiar.

Positive reinforcement is also used to address challenging behaviours, with the application of focused support strategies. More specifically, if an appropriate behaviour is displayed, the individual is positively reinforced in some way. At the same time, a challenging behaviour could also be reinforced if it occurs at a more appropriate place or time (Ministry of Social Services, 2009, p. 102). When Paul was refusing to shower, group home staff provided him with choice as to what time he would prefer showering, reflective of ecological change. During those days when he would shower, he was positively reinforced with praise from staff. As mentioned previously however, these strategies weren’t implemented in a consistent manner, which negatively influenced the success of the approach.

Reactive strategies are responses that reduce the impact of a behaviour in a timely manner, but doesn’t change the behaviour itself. The goal of this approach is to maintain the safety of the individual and others in the present. Some examples include interrupting a harmful behaviour or using minimal physical force to ensure safety, when no other option is available (Ministry of Social Services, 2009, p. 103). Paul was described to have engaged in intimidation with group home staff, where he would run towards them if they made a demand of him. As a way to prevent injury to Paul and group home staff, they would draw his attention away from a situation upon noticing his agitation, in order to avoid escalation.

Based on my experiences in providing support to individuals with complex behaviours, I observed the value and impact of these services on the lives of participants, families and service providers. Challenging behaviours can often be misinterpreted and responses can be damaging to the helping relationship. Comprehensive Behaviour Support reframes understandings of these
behaviours as communication, as a way to ensure the needs of individuals are recognized.

Overall, I believe the services provided by Outreach and Prevention Services serve to combat discrimination, as experienced by persons with complex behavioural needs.


**Ethical Considerations**

“Ethical behaviour lies at the core of every profession” (Canadian Association of Social Workers [CASW], 2005, p. 2). As a social worker, adherence to particular values and standards of practice remains essential when supporting vulnerable populations. These principles ensure that we act in the best interests of the individuals accessing support, while reinforcing the necessity of ethical practices. During the field practicum, ethical guidelines embraced by the Canadian Association of Social Workers (CASW), primarily informed my work with individuals, families and service providers. As such, this section will explore the six values described in the CASW *Code of Ethics* (2005) and their relevance to my experiences with Community Living Division.

**Respect for the Inherent Dignity and Worth of Persons**

While supporting individuals with intellectual disabilities, reinforcing the significance of self-determination became a fundamental component of my work, through the application of a person-centred approach to practice. This approach focuses on the aspirations of the individual, as opposed to past understandings of deficiency. Relevant supports are provided in the realization of these goals, instead of developing objectives based solely on the availability of resources (Mansell & Beadle-Brown, 2004, pp. 1-2). The specific needs of each participant were consistently reflected in the strategies or recommendations that I implemented, in keeping with the values occupied by the agency and the CASW.

Throughout the field practicum, I had the opportunity to meet with families and caregivers to complete assessments or to assist with any challenges they may have been experiencing. I observed that, at times, family members had opinions relating to aspects of the participant’s life, which were not necessarily reflective of the individual’s preferences. As such,
reviewing the participant’s rights, including informed consent and the role of Community Living Division in the provision of support, remained fundamental in ensuring services aligned with the participant’s goals.

**Pursuit of Social Justice**

One of the responsibilities I held as a student during the field practicum involved supporting individuals with complex behaviours. I observed that participants described to have engaged in challenging or dangerous behaviours, often experienced more barriers to achieving their goals. As a result, I worked with caregivers to provide appropriate supports to participants, while advocating for the limited use of reactive strategies and restrictive procedures. I also facilitated training relating to complex behaviours as a form of communication and recommended strategies to employ when supporting someone with behavioural concerns. I believe that sharing this knowledge better enabled families and service providers to respond to challenging actions in a way that does not punish the participant, but rather encourages exploration of meaning.

In relation to supporting individuals with behavioural needs, I participated in an abuse investigation following a service provider’s response to a participant’s challenging behaviour. This process is not uncommon within Community Living Division, as it is essential to ensure that an individual’s rights are protected, while identifying possible areas for development within agencies. In this particular situation, disciplinary action was decided upon by the service provider, while Community Living Division offered support through ongoing capacity building, including specified training modules.
Service to Humanity

As a social worker within Community Living Division, I had the opportunity to support a vulnerable population experiencing forms of oppression and discrimination as a result of disability. In doing so, I held the responsibility of ensuring that the needs of each participant were met and their rights upheld. Additionally, I would often remind myself of the authority inherent within my position, as a way to ensure my actions were reflective of the needs of the individuals I was supporting.

While completing an annual review assessment, I met a male participant residing in an approved private-service home. Upon beginning the assessment, I noticed that he was somewhat hesitant and anxious when responding to questions. When I explored the potential cause of these behaviours, I learned that he has always been nervous when meeting with social workers, due to his past experiences in the child protection system. In this situation, it was imperative to validate his feelings, while having a discussion surrounding my role in supporting him in the realization of his desired goals and aspirations. He reported that this disclosure helped in alleviating his anxiety and enabled him to feel comfortable throughout the assessment.

Integrity in Professional Practice

Since becoming a social worker several years ago, I learned the importance associated with engaging in reflection regarding my personal feelings and opinions, in the context of professional experiences. It becomes necessary to acknowledge the occurrences that come to influence the ways in which we understand the world. In doing so, we become increasingly aware of our practice, which has a positive effect within the establishment of the helping relationship.
Throughout the field practicum, I utilized a journal to reflect upon my daily experiences, while also exploring my thoughts with colleagues in the agency. In addition, I was meeting with my professional associate regularly, which enabled me to connect these learnings to the identified theories informing the practicum. These examples of ongoing reflection contributed to my knowledge relating to intellectual disability, and also challenged my thoughts stemming from previous employment and personal experiences.

Confidentiality in Professional Practice

“A cornerstone of professional social work relationships is confidentiality, with respect to all matters associated with professional services to clients” (CASW, 2005, p. 7). Protecting the personal information of the individuals whom I was supporting throughout the field practicum, was one of my fundamental responsibilities as a social worker. Upon meeting with participants and their families, all matters relating to confidentiality were discussed, as a way to establish trust within the helping relationship.

Protecting the privacy of information was also important in terms of the external environment. Matters relating to a participant were never discussed publicly and meetings were always held in a secure location. Furthermore, in the case of this report specifically, I obtained written consent from the individuals whom I would be representing and explained how I would be utilizing the information. I believe this was necessary for the completion of this report, as it is important to represent the experiences of vulnerable populations in a way that does not perpetuate oppression.

Competence in Professional Practice

Demonstrating competence as a social worker is one of the most important values guiding ethical practice. In order to provide adequate support in my role with Community Living
Division, I completed a literature review surrounding intellectual disability prior to beginning the field practicum; in addition to familiarizing myself with the services offered by the agency. This knowledge significantly informed my understandings when I began the placement. Moreover, my experiences working alongside colleagues furthered my knowledge and challenged my former conceptions of disability.

I was fortunate to have been provided with many learning opportunities throughout the field practicum as well. I participated in training relating to the Comprehensive Personal Planning and Support Policy, which explores person-centred planning and complex behaviour supports, among other topics. These training modules served as a foundation of learning, guiding my practice throughout the duration of practicum. Overall, I remained mindful of learning opportunities that became available throughout the practicum as a way to ensure I was providing support conducive to the needs of the individuals with whom I was working.
Conclusion

This final section concludes a discussion about my field practicum experiences as a graduate student with Community Living Division. During this time, I was very fortunate to have had the opportunity to learn from the participants accessing services within the agency, in addition to their families and service providers. My experiences supporting these individuals significantly informed my learning, while allowing for the development of new skills and understandings relating to intellectual disability. This section will examine the professional development arising from the practicum and visions for my future as a social worker.

Professional Development

I had many opportunities that furthered my awareness and skills as a social worker throughout the field practicum experience. Specifically, I have become more cognizant of the impact of neo-liberalism on the resources that are available to persons with intellectual disabilities, in addition to the interplay between systems in the provision of support. As a result of this knowledge, I have become more critical of policies where barriers to services exist, and more aware of my role in advocating for equal access.

Working with participants accessing support from Community Living Division enabled me to develop my skills in direct practice, and specifically in the area of complex behaviours. One responsibility I had involved the creation and implementation of behavioural strategies and recommendations to service providers. Initially, I felt overwhelmed in these tasks, as it was an area of disability in which I was unfamiliar. However, I learned a great amount of information from my colleagues, in addition to drawing upon my background in psychology when working with participants and their caregivers. This knowledge will undoubtedly inform my future practice, in that I have a more thorough understanding of behaviour as a form of communication.
Visions for the Future

My learnings resulting from the field practicum and attending the University of Regina, Master of Social Work program, have been invaluable to my growth as a social worker. I have been very fortunate to work with members of vulnerable populations, fellow students and professors, whom have inspired my interest in further education in the coming years. I believe that learning is a lifelong process and as a social worker, should remain a priority throughout my career to ensure I am working effectively with individuals seeking support. Moreover, I hope to further my skills in research-based practice, while continuing to engage in the provision of clinical counselling.

The field practicum experience at Community Living Division enabled me to grow as a social worker and as an individual. I faced challenges during this time, which only contributed to an increased sense of self-awareness and the development of new skills. I believe that Community Living Division will continue to recognize and challenge the systemic oppression that participants experience, while remaining progressive in their actions to support individuals, families and service providers, in the realization of their goals and aspirations.
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