THE MAKING OF MENTAL HEALTH POLICY: THE 1980s AND THE CHALLENGE OF SANITY IN QUEBEC AND ONTARIO

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ABSTRACT

This paper examines the current socio-political language in the formulation of mental health policy in Ontario and Quebec. "Before long," coherent and rational policy has been promised in each province to "solve" today's mental health crisis—often identified as that of "deinstitutionalization." However, there is not just one view. Here, we examine the arguments presented in the form of briefs, reports, and working documents on the part of mental health professionals, governments and unions, patient groups, and volunteer organizations in both provinces. We analyze the areas of convergence and divergence and attempt to make sense of this mass of material so important in the formulation of a sensible and sensitive government policy of action.

INTRODUCTION

Social policy formation, whatever one may wish or pretend it to be, is seldom a rational affair. Social problems are not simply studied, analyzed, and then acted upon in a "sociologically astute" manner. In the field of mental health, as in virtually every area of government policy, pressure groups exert their influence on government; each group possessing their own beliefs, conceptions of "rationality," and "obvious" paths for action.

In this paper the current socio-political language in the formulation of mental health policy in Ontario and Quebec will be examined. The object of concern is the making of a reform—of a new "new era" to follow the old "new era" of irresponsible and unprepared deinstitutionalization. In Quebec, an official, true-to-form mental health policy has been promised "before long," "to solve today's mental health crisis." While in Ontario an officially legislated policy is not on the immediate agenda, the search has been on since the late 1970s for a comprehensive "framework for planning" which will identify appropriate lines of direction for the articulation of policy. The call is for a unified, comprehensive, coherent, and rational approach, yet there is not just one view or conception of wisdom.

We will examine some of the key arguments, beliefs, and models presented to "convince"; in the form of briefs, reports, and working documents

from a variety of groups which have been designated or have taken upon themselves the role of "policy influencers." What language do they use in their attempts to influence the political will? What ideals do they appeal to? What premises do they start with? What issues do they focus on? What theories do they propose? Where are some of the convergences and divergences? The 1980s have until now been rich in what we will call *intellectual cogitation* over mental health. This overview of a mass of documents—each written with conviction, and often with as much emotion as reason—will, it is hoped, provide some insight into two very different ways of approaching the making of mental health policy.

REFORM OR PROGRESS? THE POWER OF IDEAS

Reform, says David Rothman (1980), is the designation that each generation gives to its favourite programs. Indeed, all new measures, especially those which carry strong emotional intensity, carry that label, and their enactment is seen as being synonymous with progress. However, the truth that reformists proclaim one day may very well be labelled heresy soon afterward. For reforms are based on strong-held beliefs and values, on theories which provide definitions of the situation, goals, justifications, and models for action (Boudreau, 1980, 1984; Schon, 1971). These theories provide the intellectual, moral, and emotional pressure required to convince. And convincing is the name of the game. Theories which call on noble sentiments, such as respect for human rights and personal dignity, and at the same time aptly fit the needs and interests of the prevailing socio-economic context, provide the political arena with enough energy to overcome resistances and become official policy. They then appear as such logical, appropriate, self-evident truths that very few would dare submit them to close scrutiny for fear of being labelled anti-social or anti-humanitarian. Soon these ideas become a routinized fact of the social ethos. They guide our perceptions, reduce our ethical dilemmas, and provide needed explanations in our "habitual rounds of activity" (Marchak, 1981, p. 1) until highly contradictory evidence or a sequence of disturbing events (Schon, 1971) outruns them and precipitates a state of crisis. The need then arises for new theories, intellectual reconceptualization, and models for action.

This process is by now a familiar one to observers and analysts of the many reforms undergone in the management of people who society has labelled insane, mentally/psychologically ill, or more recently, the psychiatrized. From milieu therapy to community therapy, from institutionalization to deinstitutionalization, each of these reforms was based on highly convincing theory; each one was defined as progress, a step forward, away from a dehumanizing, shameful past toward a humanitarian and just future.

Deinstitutionalization and its corollary community mental health have been called The Third, and even The Fourth Revolution—the enlightened one, legitimated by the belief that "it is desirable that individuals, to the extent possible, live independently, assume responsibility and show a desire to adjust to community living" (Mechanic, 1980, p. 166). Now it is referred to at best as an incomplete revolution and at worst an "abdication of responsibility" (McKinley, 1981, p. 229), though not yet a heresy.

DEINSTITUTIONALIZATION: AN UNSUBSTANTIATED HYPOTHESIS

It is now clear that the body of theory which in the early 1960s had made the project so very convincing and irresistible, has shown itself to have been an inadequate guide to fulfilling all its promises: more humane, just, effective, normalizing, rational, dignified, therapeutic, and, it was argued, economical care of the mentally ill. Community living (as though it meant community care, or even better, community support) was deemed by definition to be preferable to institutional "care," whatever that may have meant. As an hypothesis which needed to be tested, deinstitutionalization was mistakenly understood as a political verity, an extremely convenient truth that needed no verification.

For a time, following a purely productivist logic, statistics on dehospitalization in lieu of deinstitutionalization appeared convincing. As the belief became a more routinized policy, and with the tight-money economics providing the underwriting, fiscal logic gained precedence over therapeutic logic, and as we know, massive discharges took place before quality community care was available. We will not join here the debate as to whether the theory of deinstitutionalization originally stemmed from a "basically" humanitarian or, rather, a more "basely" economic consideration, or from a mixture of both. Motives are never simple and are almost always mixed. The key to successful convincing, however, is that motives must appear straightforward, logical, acceptable to human sensitivities, and speak the language of justice.

We know now, and have known for many years, that deinstitutionalization does not necessarily alleviate patient dehumanizing, that community life is not, by definition, rehabilitative and normalizing, and that the personal, family, and social costs of community care have been grossly underestimated. We also know, however, that deinstitutionalization is to remain on our policymakers' agenda as a necessary, though insufficient, means for improving the mental health care system. No strategic retreat seems possible or desirable, though there are calls, especially on the part of employees' unions and on the part of involved families, for a temporary moratorium.

The policy is in the process of being reconceptualized. A reform of the reform has been promised. The theory, in essence, has been accepted by all interested parties, as sensible and rational. The challenge is to make it so in actual design and practice.

NO ULTIMATE WISDOM . . .

Sadly enough, there is no source of ultimate wisdom on the question of design, nor is there any consensus on the best approach. Policy is a question of preference (Wildavsky, 1979) and there is no "correct" criterion for establishing which preference is better than another. Justice, equality, and fairness, along with rationality, are politically meaningful concepts, but they are also fluid and relative; and rationality, as today's most valued precept, is still too close to rationalization.

Yet in most Western countries and, of course, in Canadian provinces, strong pressures are being exerted on governments from all sides, namely by interested

parties, the media, and the general public, for a consistent, coherent, rational, and unified mental health policy—one that would resolve the crisis of deinstitutionalization and put an end to the nightmarish headlines found with more and more assiduity in our daily newspapers. While it was the plight of the "deinstitutionalized" which originally prompted a call for government action, the issue now appears to be the search for a master plan, one which in its very conception would provide the answers to mental health problems and even guarantee mental health to all citizens.

Concerns have broadened from deinstitutionalization and non-institutionalization of the "ill," to mental health promotion for those concerned with the quality of their lives. Deinstitutionalization is now part of a more global enterprise on the policymakers' drawing board. Yet the belief that "all that is needed is a coherent, rational, comprehensive, and consensual policy" may very well be an illusion, or as Eli Ginzberg (1977) put it, "a widespread misconception about the potential of government to accomplish whatever it sets out to do, once it is willing to spend large sums of money" (p. 9).

Nevertheless, the process of intellectual cogitation as a logical, true-to-form first step in policy design is on. It is a very time-consuming, energy-draining, difficult, and occasionally fascinating exercise.

It was in the province of Quebec in 1983 that the then Minister of Social Affairs Pierre-Marc Johnson promised, for no later than 1985, a coherent mental health policy, a policy which in 1986 is still waiting on the drawing board! It is now awaiting to be integrated into, or at least articulated alongside, an even more comprehensive health policy promised in 1985 for the near future. However, the formulation of this global health policy is awaiting the findings of a recently appointed commission of enquiry into health services . . . .

In the province of Ontario, public pressure prompted the Minister of Health in 1977 to request the Ontario Council of Health to form a Committee on Mental Services. Based on the work of four task forces and three subcommittees, on the study of 1,600 recommendations (submitted privately as well as at 15 open meetings throughout the province), on site visits, invited consultations, and examinations of previous reports, the committee concluded in its report, *Agenda for Action* (Ontario Council of Health, 1979), that a senior coordinator of mental health services in the Ministry of Health must be appointed to conduct a review and assessment of the current state of mental health services in Ontario and to recommend policy direction for the future development and delivery of these services. In other words, the commitee which was formed to find out what should be done, concluded that someone should be appointed to find out what should be done! Dr. G.F. Heseltine, psychiatrist and chairman of the Department of Psychiatry at the University of Western Ontario, was given this task. Later in this paper, we will examine some of the key ideas in his report.

The political will for a reconceptualization of mental health services typically gives birth to a flurry of documents, studies, briefs and counterbriefs, discussion papers, commissions and subcommisions, all bringing in a flood of testimonies, interim reports, and final reports, all of which, it is hoped, find their way to the proper desks in the proper planning divisions of the mental health sections of the appropriate ministries. Apart from commissioned parties specifically requested by governments to investigate, report, and make recommendations, who are the

interested parties who feel personally and collectively responsible for expressing their viewpoints, influencing policy, and defending personal or corporate interests? What issues will they focus on? What beliefs, values, and convictions will they voice?

Some of these parties are the private citizens, former patients, or "fed-up" neighbours who recently presented their views to a self-appointed subcommission of the *Commission des Affaires sociales du Québec* on the question of social insertion of mentally handicapped people. Others are professionals involved as care-givers, service-givers, or support-givers, depending on their ideology; voluntary associations such as the Canadian Mental Health Association (CMHA); self-help groups and associations of alternative groups which speak of their personal beliefs and experiences; associations of reception centres or *centres d'accueil* asking for more subsidies; directors of institutions in the process of being "dehospitalized," with patients being returned to their communities; and unionized employees of those same institutions who believe "deinstitutionalization of patients should also mean deinstitutionalization, retraining and relocation of staff in jobs of equal status and income" (Marshall, 1982, p. 155). They are also, of course, the bureaucrats, technocrats, and government planners whose jobs are to draft such working and policy papers. From all parties concerned, the call is for a coherent, rational, unified mental health *framework* for Ontario, or *official policy* for Quebec. The belief, or should we say the illusion, is that it can be done!

MORE GOLDEN WORDS AND CONCRETE NECESSITIES

A preliminary reading of such documents gives the impression that the most commonly used concept on which there is unilateral agreement, is that of *more*: more rigorous planning and programming, rationality, systematization, accessibility, continuity, availability, diversification, complementarity, effectiveness, quality, value for money. These are the golden words of our time, born out of the late '60s and early '70s and still with us in the '80s as unfulfilled promises. They are highly desirable goals, rooted in the belief that they represent an attainable reality if concerned parties would cooperate, and above all, if only there were adequate leadership, as long as it was not centralized! This is indeed the stance taken in Ontario's Heseltine interim (1982) and final (1983) reports which recommend that the Ministry of Health take the "lead role" in all institutional and community mental health matters, yet emphasize that mental health delivery must be "a sum total effort of different ministries and of different levels of government working to one cooperative end, that is, the provision of services to support the treatment and rehabilitation of the patient in the community" (1983, p. 11). "If this type of cooperation does not occur at the top," the report continues, "it surely cannot percolate down to the local level" (1982, p. I.2).

Cooperation is a very desirable thing indeed, especially if a "system" is to function in a unified, "systematic" fashion—as the word dictates. Yet, it implies that ministries are all equally reasonable and that their reasoning can mesh harmoniously. It also implies that one can actually speak of a unified mental health system, unless one chooses to speak of a mental health forum (*problématique*), as does one advisory body to the Quebec Ministry of Health and Social Services (un-

til recently called the Ministry of Social Affairs), the *Comité de la Santé mentale* (1985), in a series of pocket-book-size briefs called *Avis*, issued in preparation for the formulation of Quebec's future mental health policy.

In addition to being repeatedly associated with what one could conceive as being highly valued, but vague, abstract imperatives, *more*, in most reports, is also associated with such concrete necessities as: crisis intervention services, after-care programs, residential facilities, group homes, boarding homes and lodging houses, home care services, foster family rehabilitation programs, sheltered workshops, and work programs. Nobody would deny their place at the top of the list of urgent priorities. There is also a call for more imagination and creativity in the creation of alternatives, self-help groups, and citizens' advocacy programs.

This issue is very closely linked with that of privatization, a topic approached in surprisingly few reports and even then in the form of a passing comment, almost as though it were a shameful but unavoidable fact of life equated with villainous deeds such as benefitting from another person's misfortune. But this must be the subject of another paper . . . .

The key concerns here are regulation and costs. While some call for more regulation and government overseeing, others want less regulation and more room for imagination, expansion, and creativity (*Hôpital Rivière des Prairies*, 1985, p. 588). All call for more services; but "more" costs more, unless resources are reallocated, and resource allocation itself is a source of contention.

THE REALLOCATION OF RESOURCES: HOSPITAL VERSUS COMMUNITY?

For those who campaign for more community-based services, the statistics are convincing and accompany increasingly forceful demands for justice. Indeed, it is well known that hospitals swallow the greatest porportion of all mental health expenditures. It is reported that more than 68% of patients in Quebec receive services out of the hospital, while 58% of the total budget (56% in Ontario) is used by institutions.

Yet, statistics do not really speak for themselves. There is strong support for the hospital and for good quality in-patient care. "We still need the psychiatric hospital as a milieu which welcomes and which permits," says Carlo Sterlin (1984, p. 60), among a growing number of others . . . .

In Quebec, appearing before the *Commission des Affaires sociales*, Dr. Frederic Grunberg, Director of Research at the Hôpital Louis-H. Lafontaine and a member of the *Comité de la Santé mentale* (advisory to the Ministry of Health and Social Services), attempts to destroy the "myth which exists, perhaps even within the government, that there is a lot of 'fat' in the institutions which costs a lot of money and that we could reallocate these funds to put them at the service of the community. For deinstitutionalization to succeed, we must add resources . . . . For a humanization of our institutions, we must also add resources" (*Comité de la Santé mentale*, 1985, p. 310).[1]

In Ontario, the Heseltine report, *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective* (1983), takes a similar stance: "We should not be so seduced by the excitements of developing 'community' (in the sense of non-hospital) programs that we neglect to maintain active interest in the

quality of our psychiatric facilities" (1983, p. 8).

Heseltine (1983) appeals to reason, and realism means that "the ideal is not always achievable" (p. 4). "There are always constraints," one of which is that "dollars available for health care are not unlimited" (p. 4). Heseltine further emphasizes that "over the coming years, we, the taxpayers, may be faced with choosing between what is preferable and what is affordable" (1983, p. 207). The first affordable measure is "to make the best possible use of all existing resources." The second is to think in terms of developing a balanced service system. Thus, the hospital-versus-community debate is resolved at the level of terminology by speaking of a community-based service system meeting the needs of the community through a continuum of services, from lay counselling to specialized hospital care. In other words, given the scarcity of resources, we should not complain that general and psychiatric hospitals use so much money, since they are also part of the range of community services. The somewhat questionable argument goes, "it is a resource based in, and owned by, the community and therefore a community-based service." While Heseltine, in his final report, has not retained his key concept of "pivotal hospital" (from his interim report), which won him much scorn for his "hospital-centered" language, he is adamantly opposed to any notion of community services which would exclude the hospital. True to the now "old" medical paradigm, services—even termed "community-based"—are still "in-hospital" or "out-of-hospital" in nature and philosophy:

> A common notion of "community" appears to exclude the hospital, or to view non-hospital programs based in the community as an alternative, and a superior one at that, to existing hospital (both psychiatric hospital and general hospital unit) programs. This point of view can have harmful consequences . . . . One has only to look at some American jurisdictions where psychiatric hospital facilities have been replaced to a large extent by "community" mental health programs to see the effects—the chronically mentally ill have often been overlooked (Heseltine, 1983, p. 8).

However, it is not quite clear whether Heseltine believes the chronically ill belong in the hospital or whether it is the "community" programs that were inadequate . . . . Nor does one understand why Heseltine limits his example of gloom to the United States. According to a report by the Ontario Public Service Employees' Union (OPSEU) entitled *Madness, An Indictment of the Mental Health Care System in Ontario* (Marshall, 1982), there is ample evidence of this at home: "For the patients and their families, the situation is one of desperation. For the staff, it is one of tremendous frustration and distress. For all of us, it is one of shame" (p. 3). For the OPSEU, "deinstitutionalization and community care are a wonderful idea—but it hasn't been tried yet" (p. 147). In English or in French, in Ontario or in Quebec, unions speak the same language: "moratorium" (*Confédération des syndicats nationaux* (CSN), 1985; *Fédération des travailleurs du Québec, Syndicat de la fonction publique* (FTQ), 1985; *Ordre des infirmières et infirmiers du Québec* (OIIQ), 1985; *Fédération des syndicats professionnels d'infirmières et infirmiers du Québec* (FSPIIQ) & *Centrale des enseignants du Québec* (CEQ), 1985).

It is also the language spoken by the mother of a 35-year-old mentally handicapped man in a personal testimony to the Quebec subcommission on reinsertion:

> As far as deinstitutionalization is concerned and normalization, they are a joke and they should be stopped until the proper plans are made, the proper kinds of money are put forth to make the services run properly and well. I see people out there who have been deinstitutionalized, who are living in abject poverty, filth . . . . I would not want to see my kid out living like that . . . . I think it is a scandal. I think it should be stopped . . . it was going to save millions and millions of dollars, but it has been at the expense of the handicapped people and their families who suffer enormously just watching what is happening to them. I will not allow that as long as I am alive. When I am dead, there is nothing I can do about, but I am hoping (Farley, 1985, S-CAS: 671) (Original in English).

Such statements, which may represent the feelings of large numbers of those most closely affected by the policy, are not, however, typical of the language encountered in the briefs presented by the grassroots level, families and friends, citizens' committees, and the psychiatrized; in other words by those in the "natural milieu." Negativism is not the rule; on the contrary, these groups profoundly adhere to the *Lalondian* (from Marc Lalonde, 1974) ideology of individual responsibility, which they have coupled with that of community solidarity.

LET US LEAVE TO THE COMMUNITY WHAT BELONGS TO THE COMMUNITY

At the grassroots level, belief in deinstitutionalization is accompanied by an enthusiastic expression of faith in the individual and collective potential of human involvement and mutual help.

Regroupement Alternance, an association of citizens involved in various alternative projects, has used its motto as the title of a 1985 brief: *Laissons à la communauté ce qui revient à la communauté* (Let us leave to the community what belongs to the community). They present a testimony of various experiences of alternatives involving citizens of all ages with the community spirit bug (*la piqûre du communautaire*):

> In our alternatives, we do not dream of the community, we do not discuss it behind our desks, we do not theorize about it, let alone intellectualize it; we live it intensely, engage in various projects, doing militant work within citizens' committees, neighbourhood resources, housing cooperatives, school boards, parents' associations, etc. Instead of getting involved in various sports, leisure or cultural activities, we get involved in the social milieu with our most disadvantaged fellow citizens (*Regroupement Alternance*, 1985, p. 568).

For the citizens' advocates from Montreal's West Island who cater to a large community of deinstitutionalized patients, the results obtained offer an undeniable proof of the appropriateness of their approach:

> And now, if you met that lady, you would never dream that she was a psychiatric patient. She still is a psychiatric patient and always will be, but she came to our Christmas party last year and I did not recognize her. She just looked absolutely gorgeous, all dressed up, and she was able, out of her welfare money, to save enough for a trip out to Winnipeg . . . . She still has her advocate . . . and sees her occasionally (*Parrainage civique de la banlieue ouest de Montréal*, 1985, p. 668).

The other part of their message soon follows: the demand for a drastic injection of funds, namely government investment, in their conception of the therapeutic reality.

The same message is heard from such self-help groups as Self-help Against Depression (SHAD), a network of people who help others to overcome depression and anxiety:

> Our philosophy is one of hope in the future, trust in ourselves, caring for one another, not just [as] an ideal, but practiced everyday by our SHAD teams (45 of them) . . . . The only reward the volunteers get is our appreciation and the knowledge that they are helping others . . . . Our problem is frustration because of lack of security. Much time is spent applying for grants, researching where funds may be available, reporting on activities, reporting on where funds are spent, reporting and accounting . . . . It would help us if we knew where our funds were coming from next so we could save our time to serve our clients (SHAD, 1985, p. 431).

The ideology is attractive, it calls on noble sentiments. Its appeal is not limited to the people at the grassroots level who find in it a form of revaluation—and often a job. The reality of overcrowded hospital wards, of institutions claiming near-bankruptcy and of the multifaceted nature of mental health problems makes it even more attractive to some hospital administrators and government policy consultants. First in line here is the *Mémoire Beausoleil-Godin*, presented in 1983 to the Honourable Pierre-Marc Johnson, then minister of social affairs. Léo-Paul Beausoleil is an accountant by profession and a former general director of one of the province's two largest psychiatric hospitals, the Centre Hospitalier Robert Giffard (the former St-Michel-Archange Hospital which provided asylum for nearly 6,000 patients in 1960). Michel Godin acted as a consultant on the Castonguay commission of the late '60s and later became an upper-level civil servant within the Ministry of Social Affairs (a creation of the Castonguay reform with its vision of a global health and welfare system). Without exaggeration, he qualifies as a "professional cogitator." In their brief, both men strongly criticize the 1970 reform in which they took active parts themselves as designers and implementors:

> The last fifteen years have adequately shown that we are virtually at the same point nowadays as we were then. If we choose to maintain the status quo, we might as well admit that we would be at the very same point fifteen years from now . . . . This course of events will push many an individual into the throes of mental illness, into the bosom of institutions, the "mothers of craziness," into hospitalism. Some will be so distraught and anguished that they will die, while others will be sacrificed by the "system," all because of our foolishness (Beausoleil & Godin, 1983, p. 141).

This provocative rhetoric aims to attract government attention and public awareness to an alternative; a new representation of the situation and a model for action.

The proposed solution, which they acknowledge as requiring "a lot of courage," is to deprofessionalize the field, vulgarize expertise, and call upon "natural helpers" (*aidants naturels*). They urge the state to recognize an individual's right to control his or her illness and problems of *mal-vie*, which, they say, professionals have appropriated until now. They call on professionals to share their knowledge with the general public "so that the population, in-

dividuals, community resources, alternatives or others can acquire the means to solve their own problems (. . .) in their own environment" (Beausoleil & Godin, 1983, p. 14). While hospitalization is not excluded from their vision, they emphasize that "the curative model should not prevail over the preventative, nor should professional expertise prevail over individual and collective potential; the institution must not prevail over the natural living milieu, and mental illness should not prevail over mental health" (1983, p. 14).

> The general public's problems, hardships and needs are construed and labelled in such a negative way that resources and "society" can only think of them in terms of illnesses, psychiatric needs, medical and professional specialization, and "overspecialization." This misconception of needs leaves little chance of success for those individuals who might have escaped [this plight], and gives the population little chance to try and exercise its rights to mental health; thus, it minimizes the importance of each and every one of us, leaves the door open to mistakes and prevents all social partners from meeting the challenges they are faced with (Adapted) (Beausoleil & Godin, 1983, p. 122).

This view of things, which the Quebec media have called a trifle utopian, has now acquired momentum among influential model-makers. The idea is being rearticulated, refined, and meshed with a bio-psycho-social conception of the individual and presented as the new ecological model. As a matter of fact, it could very well become the preferred rhetoric among Quebec's policy-makers, given the necessary improvements. It could also be a passing phase!

Objectif: Santé, an August, 1984, report of the *Conseil des Affaires sociales et de la Famille* to the Honourable Pierre-Marc Johnson on the issue of health promotion, has become the key document outlining the basic foundations and objectives of this ecological model as applied to health in general. Published by the Quebec government in an attempt to stimulate thinking among interested parties, *Objectif: Santé* has acquired policy-influencing strength. Its preferred model may very well become the next step in a succession of theories which have acquired policy-making dominance over the Quebec psychiatric system since its days as an "asylum system" legitimized by the belief that "craziness cannot be cured" (Boudreau, 1984).[2]

The ecological mode is presented as more enlightened than a model giving sole responsibility for a so-called illness to professionals (1961-70) and more global than one focusing on a system's structure and management (1970+) as a way to deal with a population's health and welfare; it concerns society as a whole, and that is equated with justice, and progress.

THE ECOLOGICAL MODEL AS AN APPROACH TO MENTAL HEALTH

Already, this ecological model, as defined mainly in *Objectif: Santé*, has been the source of inspiration for the *Direction générale de la Santé* (DGS) of the *Ministère des Affaires sociales* (now the *Ministère de la Santé et des Services sociaux*) in adopting their own conceptual framework for mental health. This framework, they say, is based on human values, the values of a society, the most fundamental of which is:

> What I can do for the welfare of . . . my child, my parents . . . my friend, neighbours, my fellow citizens (DGS, 1985, p. 3).

In the very first pages of their consultation paper on the elements of a mental health policy, entitled *L'intervention en santé mentale: Du modèle institutionnel vers le modèle écologique* (DGS, 1985), those responsible for mental health at the DGS focus on the "I" and the "we," emphasizing a value which they deem to be "akin to 'love' between humans [and which] must animate not only relations between family and friends, but all social relations and especially professional relations" (p. 3). Moreover, the official message sent directly by the Ministry of Health and Social Services (1985) is clear: *Mental Health, It's for All of Us to Decide* says the title of its latest working document drawn for public discussion and feedback. The document emphasizes collective responsibility: Mental health is a social project, the project of a society.

The target of intervention is the general population of the province of Quebec where statistics on suicide, hospitalization and rehospitalization, as well as CNS (central nervous system) drug prescriptions are said to show that mental health is in worse shape than ever before (Plante, 1984).

Thus, the focus of concern for policy-makers in the area of mental health seems to be in the process of shifting again, possibly at the expense of those who society so easily rejects (Boudreau, 1986). From the crazy who received custodial care under the asylum system prior to 1960, to the mentally ill who were deinstitutionalized in the mid-'60s and promised professional treatment as well as a normalized life, the focus has broadened to clients, beneficiaries, and consumers of the health and welfare system for whom mental health was both a right and a government commitment (Boudreau, 1984). Nowadays, mental health, or rather social health, is the personal and collective responsibility of the entire population of Quebec. Regardless of the attractiveness of the ideology, one is tempted to recall here Alexander Leighton's warning (1982) that when a problem cannot be solved, or when a goal cannot be attained, one changes its orientation, modifies its contents; one creates new, broader, and nobler objectives which embody the first one and serve to minimize it. So, in order to avoid facing the reality of disappointed hopes and promises, one changes the conceptual schema, one creates new, more fascinating hopes; hopes that are more beautiful but more vague, yet infinitely desirable, and cannot but gain universal praise.

MENTAL HEALTH OR SOCIAL HEALTH?

Mental health as an ecological concept is defined as adaptation, or coping, resulting in a "dynamic and harmonious equilibrium between a person and his/her environment" (DGS, 1985, p. 6). It is no longer "the fulfillment of harmonious physical and mental self-growth" as the Castonguay Report (1970) liked to call it. It now seeks to be more grounded, less abstract. It has become, in the proposed language: "the result of a dynamic process of adaptation of the individual (as a bio-psycho-social entity) to his environment or milieu, in a process of growth and self-actualization" (DGS, 1985, p. 4). The definition which concentrates on adaptation to one's environment as the key indicator of mental health is now believed to be "operational" since "restrictions from usual activities can be measured" (DGS, 1985, p. 7). Whether or not growth and self-

TABLE 1

Characteristics of Theories in Dominance in the Quebec Psychiatric System

Characteristics of Theories	Phase I (— 1960)	Phase II (1961-1970)	Phase III (1970 +)	? Phase IV (1985 +) ?
1. System	"Asylum" system	"Psychiatric" system	Global "health and welfare" system	"Society" as a whole
2. Promoters	Religious orders—old professional bourgeoisie	Young psychiatrists—new professional bourgeoisie	The state, social planners, and "bureaucratic rationalizers"	Various groups with a variety of interests: alternative groups, voluntary associations, citizens' committees, psychiatrized, ecologists, administrators, government bodies
3. Dominant theme	*Craziness* cannot be cured	*Mental illness* is an illness like any other	*Mental health* is a right for everyone	*Social health* is an individual and collective responsibility
4. Official goal	Salvation in heaven	Treatment and social reinsertion	Fulfillment of harmonious physical and mental self-growth	Harmonious adaptation of individual to environment
5. Ideological source	Credo of Catholic church	The Bédard, Lazure, and Roberts report (1960)	The Castonguay-Nepveu report (1970)	The Lalonde Report (enriched) & *Objectif: Santé*
6. Representation of the situation and responsibility	Religious orders are the most devoted and thus the most competent providers of care and managers of the system	Confidence in experts—mental illness is the responsibility of professionals	Belief in the managerial logic of the state being legitimately responsible for the collective well-being	Belief in individual potential, mutual help, and solidarity
7. Model for action	Custodial, institutional model	Medical curative model; individualized psychiatric care and deinstitutionalization	Integrated holistic model; public health care	Ecological model (bio-psycho-culturo-social model)
8. Logic	Feudalistic	Liberalistic	Social-democratic	Unique blend of individualism and collectivism
9. Target of intervention	*Le fou*	The mentally ill patient	The client, beneficiary, consumer of services	The entire Quebec population

actualization or dynamic and harmonious equilibrium are measurable is open to debate, but what stands out most is that such a focus on adaptation or coping tends to present the broader socio-economic environment as well as the immediate milieu a person lives in, loves in, works in, and must cope with as nonproblematic. The onus of changing and of taking charge is put precisely on the individual who cannot cope and then on his or her family, friends, and close relations.

Objectif: Santé (1984) explains that the ecological approach, as inspired from Lalonde's *New Perspective on Health* (1974), is based on the firm conviction that a natural and instinctive autonomy, a power of regeneration, exists in all

human beings. "Individual responsibility is inherent to human nature" (p. 22), says the 1984 report, a decade after its predecessor. Proponents of the model, however, cannot ignore that such an individualistic position has been deemed "politically and theoretically conservative, in that it transfers the burden of the blame for problems from the health care system and providers to consumers" (Labonté, 1981, p. 8) and the burden of responsibility for intervention from governments to citizens. One might say that the ecological approach as presented here attempts to cut short any accusation of "blaming the victim" by elaborating what we shall call a *collectivized individualistic approach. Objectif: Santé* goes as far as calling this unique blend of individualism and collectivism "*du Lalonde enrichi*"! So, while Lalonde's report drew criticism for de-emphasizing the social and collective responsibility of improved health (Evans, 1982; Weale, 1982), the ecological approach enriches the position: responsibility, even though primarily individual, is shared collectively. One learns to cope with the help of friends, family, and natural helpers in one's natural milieu where real life is what it's all about. The ecological approach prefers a strategy of intervention whereby the person (who is never described as ill but as suffering from mental health problems, maladaptation, or stress) along with his relatives, family, and friends, plays the active role. The role of the professional and of a mental health service system, therefore, is to provide support, to inspire, to inform, "to assist the person and his/her family in their strategy of adaptation to the milieu," and to adapt to their needs (DGS, 1985, p. 46). Since mental health problems are linked with one's life experiences, any therapeutic intervention must occur within one's natural milieu where real, everyday life is lived. The entire mental health system must take on a community dimension, become *communautarisé* (DGS, 1985, p. 29), and this beyond the usually understood notion of community mental health.

According to the more skeptical, mostly professionals who do not appreciate the apparent de-emphasis on their expertise, this "natural milieu appears to have become the fashionable miracle cure for all the ills afflicting our society and [the means] to provide relief to our taxpayers who are even more afflicted!" (FSPIIQ & CEQ, 1985, p. 489).

The prescription is indeed, out of the sphere of professional expertise and dominance. The pill may be difficult to swallow and require "a lot of courage" from all citizens, although indeed, perhaps not as taxpayers; the point is that it is hoped it will be effective at last:

> Respect, dialogue and mutual help between Quebecers are not only the best safeguards of one's mental health but the essential tools to counter suffering, solitude, the aches and the pains of living, and to help overcome the difficulties of life (DGS, 1985, p. 4).

The language of citizen's advocates and self-help groups applied to all of society has become the preferred language of policy-influencers within the Ministry of Health and Social Services. It is not, and far from it, the revolutionary language of the social ecologists of the 1960s for whom creating a positive mental health environment entailed influencing the broader socio-economic and political structures of that setting, following extensive criticism of the capitalist state and its so-called exploitative, alienating economic system. Such language, which called for revolutionary action, does not have good currency for today's proponents of the ecological model in mental health. While the ecological project

of the '80s in the area of mental health has not adopted the neo-marxist language of the political activitist of the 1960s, it has retained a strong idealistic tone.

Specialists, ecologists say, "cannot artificially create the social conditions conducive to the maintenance and reinstatement of mental health. Each and every Quebecer must contribute" (DGS, 1985, p. 4).

Social and collective responsibility as the missing ingredients in Lalonde's New Perspective are understood as equivalent to mutual help in coping with an environment which they do not question very seriously. The environment which, according to their approach needs changing, is the social environment. Mental health, as "a dynamic and harmonious equilibrium between a person and his/her environment" (DGS, 1985, p. 6), is to be equated with social health, namely with a society based on human solidarity:

> The well-being of each Quebecer commands that we go against the anonymity and the indifference which prevail in our society as well as the rejection and intolerance present in our relationships. We must interest ourselves in the other, we must care about his destiny and help one another mutually (DGS, 1985, p. 4).

Under their pen, mutual help, love, and social solidarity become a government precept. Blaming the victim might then take on a more collective dimension and extend to blaming the quality of human relationships in an intolerant, rejecting society which denies its responsibility and is therefore unhealthy.

TAMING THE COMMUNITY: A HIGH PRIORITY

Information, public education, and awareness therefore become key words, high priorities for those who endorse this world view and speak of "taming the community" (*Centre Régional de Santé et de Services Sociaux*-Montérigée, 1985, p. 379), of changing mentalities (*Regroupement des ressources alternatives* & P.A.L., Inc., 1985, p. 386), of breaking the wall of indifference and even rejection, of dispelling myths (CMHA Ontario, 1981, p. 42; CMHA Quebec, 1985, p. 462) through publicity campaigns and public debates. They stress the need to make the various milieus (schools, workplaces, police forces, municipalities, neighbourhoods) aware of their responsibilities. They emphasize the need for training and improving the skills of volunteers and self-help groups, as well as for guidelines for the police on how to intervene preventatively in crisis situations and reinsertion problems. They also call for the reeducation of professionals in the new philosophy and mode of action (DGS, 1985). Knowing that the shift from the institutional model to an ecological one may take a while, the *Direction générale de la Santé* suggests an intermediate model which should make the transition possible within approximately 10 years.

We will not go into all the details of this model. Of course, deinstitutionalization, non-institutionalization, and the reallocation of resources by institutions must be imposed: "Should an institution not develop or not respect a deinstitutionalization plan, there will be annual budgetary constraints" (DGS, 1985, p. 78). Moreover, asylums will be closed and turned into cultural centres (DGS, 1985). Maybe so, yet how can a government impose mutual help on a collectivity, a voting collectivity!

In seeking to transform the asylum into a museum, and society into a gigan-

tic self-help group, the ecological model might be called more than "a trifle utopian." Looking at the proposed 10-year time frame, the DGS may be accused of daydreaming. One is always astonished by the unrealistic deadlines model-makers and policy-makers set for their projects.

While the project undeniably rests on very noble ideas, there is a considerable difference between people getting together of their own accord (because they share similar problems) for the explicit purpose of providing each other with the necessary support to improve their life situation, and a government making mutual help a social ethos as a foundation to its mental health policy. Building such a policy on the assumption that people, because they instinctively seek self-improvement, will accept solidarity rather than competition as the enlightened or "rational" way, is taking a serious chance with the future. Indeed, it may be a drastic overestimation of people's concern for the mental health of others or for social health as a goal. For example, when asked if they would welcome a physically or mentally handicapped person for an afternoon visit or for a meal, 80% of a sample of 1,200 Quebecers answered "no" (Mélançon-Ouellet, 1980). One would wonder even about the 20% who said yes, what the response would be if the "guest" were present and ready to eat.

"Since mental health is the result of a dynamic process of adaptation to one's environment, the onus is first on the individual and second on his immediate living environment: family, friends, neighbours, community groups; his "*milieu de vie*" (DGS, 1985, p. 13). While this statement appears to be reasonable, rational, and just, it may actually be very unreasonable, irrational, and unjust to expect everyone to agree with it at all times and to build a mental health policy on this belief. To appeal to community solidarity, mutual help, and support as a complement to mental health services is not new, but to make it the foundation of a grandiose vision of a mentally healthy society may very well be little more than an exercise in rhetoric or technocratic idealism.

CONCLUSION: BETWEEN TWO LANGUAGES . . .

The promise of a mental health policy for Quebec has yet to be fulfilled. While the future can be anticipated, but not predicted with accuracy, one might risk anticipating that in the end such a policy (as a unique, rational, coherent, comprehensive whole) might remain a promise and not come into effect. But again, one could easily be wrong. For, *la machine est en marche*, and the promise is taken seriously by Quebec's new Minister of Health and Social Services, Mme Thérèse Lavoie-Roux, who, in July, 1986, appointed a working group to draft a new policy. Even as a promise, this mental health policy has had a profound impact on the province and its system for the delivery of psychiatric-mental health services. In Ontario, the investigation of the mental health service system and the attempt to draw a framework for planning and an Agenda for Action has also triggered a highly fruitful and intensive process of intellectual cogitation, public consultation, problem-sharing, and model-building.

The briefs, reports, and working documents mentioned here, as well as many others, represent countless hours of thinking, discussing, debating, and attempting to convince; and convincing they are. Each is persuasive in its own way, whether it is a mother calling for a moratorium on deinstitutionalization based on

what she has seen; citizens' advocates pleading for increased community involvement based on their achievements; unionized hospital workers wishing to protect their jobs and to have a say in the decision-making process that affects both them and the patients; parents and friends of mental patients proclaiming, "In theory, the family should be a part of the therapeutic team. In practice, it is completely ignored" (*Regroupement des parents et amis*, 1985, p. 502); whether it is Heseltine warning his readers: "I am a psychiatrist and admittedly have a medical treatment bias" (1983, p. 7), though he considers the medical vs. non-medical issue to be a "non-issue" when concerned with the development of a balanced service system; or whether it is the likes of Beausoleil and Godin (1983) calling for deprofessionalization and demedicalization of the field and demanding that expertise be shared with the natural milieu; or again, whether it is psychiatrists and social workers who see this as a dangerous trend (*Association des psychiatres du Québec*, 1985; *Corporation professionelle des travailleurs sociales du Québec*, 1985).

However, what stands out amid the debates is the crucial difference in representation of the situation found between the pragmatism typified in Ontario's Heseltine report and the idealism of Quebec's model-builders within the Ministry of Health and Social Services.

It is the crucial difference between those who believe, as Heseltine does, that "the Ontario people enjoy a level of health care service that is equalled in only a few other jurisdictions and surpassed by none" (1983, p. 1), and those who maintain that the psychiatric system in Quebec is the same as it was 15 years ago: damaging and hazardous to one's health. It is the difference between those who believe there are "a few gaps to be filled" and "services which need strengthening" (Heseltine, 1983, p. 2) in the present system, and those who put their faith in the potential of a new, healthy society.

It is also the difference between those who, in line with the welfare state ideology, believe it is first and foremost the responsibility of the state and its various ministries working together to provide, "from the top down," the most balanced mental health system, inside and outside the hospital; and those who believe the primary responsibility is to the individual, his or her close kin, and the natural helpers in the natural milieu. Top-down or bottom up? Who is conservative and who progressive? Do labels any longer apply?

It is also the difference between those who focus explicitly and primarily on problems of system coordination, planning and programming, financing and cost-efficiency, and those who focus on problems of public awareness and education, dispelling myths, and taming the community.

It is also the difference between those who speak of regional, district, local levels of care and those who speak of family, friends, neighbours, and natural helpers.

It is the difference between those who speak of respecting the quality of hospital care, regardless of deinstitutionalization, and those who speak of "respecting the integrity of the social fabric" with "non-institutionalization" (DGS, 1985, p. 61); the difference between those who focus on a balanced service system and those who focus on a harmonious balance between the individual and his or her environment; and between those who speak of professional care in

community-based services, and those who speak of professional support in the natural milieu.

It is the difference between those who focus on "mental illness" and those who speak of "mental health problems"; between those whose primary targets are "the people suffering from acute and serious mental disease" (Heseltine, 1983, p. X-iii) and those whose target is the entire Quebec population; between those who put their faith in system effectiveness and those who put it in the effectiveness of mutual help, love, social support, and solidarity.

It is the difference between those who call for realism and warn policy-makers against the dangers of striving for too many goals versus a few priorities, and those who emphasize the multifaceted nature of mental health and endorse a bio-psycho-culturo-spirituo-social vision of intervention; between *prendre en charge* and *se prendre en charge*, that is, between helping and coping; between those who speak of "case managers" (Heseltine, 1983) and those who emphasize a relation of "equality" between the intervener and the client (DGS, 1985, p. 72).

It is the difference between those for whom rationality means the ideal is not always attainable and who believe a choice must be made between what is preferable and what is affordable, and those who proclaim that it is only a matter of time and courage before their ideal model becomes a reality.

Finally, it is the difference between the faithfulness to the tradition of pragmatism and incrementalism which has characterized social policy-making in Ontario (MacDonald, 1985) and the consistency with the technocratic idealism which has characterized social reform in Quebec since the beginnings of the Quiet Revolution, and which has known no match in the total reconceptualization of the health and welfare system brought forth by the Castonguay reform in the '70s. The Quebec state and its bureaucratic rationalizers, says Marc Renaud (1984), have turned the health and welfare sector into a laboratory for social experimentation without parallel in other Western industrialized countries.

Social design, experimentation, and grandiose visions are, indeed, the specialty of these government-paid professional cogitators. During the 1970s the state, defining itself as *l'Etat-providence*, while intervening in the name of and for the good of the collectivity, has made many promises and acquired unprecedented power. Now, as the belief that the welfare state can provide an abundance of services is recognized as an illusion (Kervasdoué, Kimberly, & Rodwin, 1984), the political policy must take a new stance: it is not up to the "good state" to work for the collectivity but rather, it is up to the "good citizen" to work for that collectivity, and for the good of the state.

While the ecological model, with its innovative ideals, appeals to a variety of groups with a variety of interests, and even though such ideals could potentially get the state "off the hook" and comply with the ideological needs of the economic context of slow growth, it is a model which needs some serious ironing before it can enter the political arena.

One may argue that "the definition of good mental health . . . must include the definition of a 'healthy society' " (Love, Coburn, & Kaufert, 1984), yet one must be wary of building new illusions. Indeed, policy must primarily evaluate not "the societal contribution to mental health" but, as Love, Coburn, and Kaufert point out, "the societal contribution to mental ill-health" (1984, p. 310).

This may be the better means to the formulation of a true ecological paradigm.

Between the Heseltine report's (1983) warning that "we should not be so seduced by the excitement of developing community programs that we neglect the need to maintain active interest in the quality of our psychiatric facilities" (p. 8) and the excitement of designing the ultimate healthy society at the risk of forgetting once more those whom society remembers or forgets at its own convenience; is there a happy medium?

This is the challenge of sanity for the 1980s.

NOTES

1. Quotations taken from Quebec documents have been translated by the author.
2. This succession of prevailing theories (see Table 1) was neither an easy nor an automatic process. The movement from one to the next is directly related to power and to conflict between interest groups who, through the interplay of interest and commitment, are pushing their theories in their own bid for dominance. As Schon (1971) writes: "Ideas are vehicles through which persons and agencies gain power. When individuals push or ride ideas, they also seek to establish their own dominance" (p. 18). This process, as it applies to the Quebec psychiatric system, has been examined extensively in my book entitled *De l'Asile à la Santé mentale* (1984).

RESUME

Cet article examine le langage socio-politique utilisé actuellement pour formuler une politique de santé mentale en Ontario et au Québec. Depuis longtemps on a promis, dans ces deux provinces, une politique pour résoudre la crise actuelle de la santé mentale, souvent identifiée comme une crise de désinstitutionnalisation. Il n'existe cependant pas un point de vue unique. On examine ici les arguments présentés dans les mémoires, les rapports, et les documents de travail par des professionnels de la santé mentale, des gouvernements, des syndicats, des groupes de patients, et des organismes bénévoles dans les deux provinces. On fait aussi l'analyse des convergences et des divergences pour tenter de donner un sens à cette masse de documents si importante pour formuler une politique gouvernementale qui répond adéquatement aux besoins.

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