The Community-Based Mental Health System: What Does It Mean?

Deena White[1]
Département de sociologie and the
Groupe de recherche sur les aspects sociaux de la prévention (GRASP)
Université de Montréal

Introduction

There seems to exist a near-consensus in the West regarding the need to strengthen the community base with respect to care for people with mental health problems. One of the reasons for this interest lies with the realization that medication in and of itself has not effectively managed the social problems associated with the deinstitutionalization of people diagnosed as mentally ill. Indeed, as an isolated strategy for dealing with this population, a strictly medical form of intervention has proven to carry social consequences, such as increasing social assistance demands, which are rendering the "mentally ill" more and more problematic under the political economic conditions characteristic of many contemporary societies. In this light, the development of coherent community-based mental health care systems has come to be seen as a necessary supplement to hospital-centred psychiatric systems.

However, there is no consensus with respect to the objectives and characteristics of a community-based mental health system (Renaud, Mercier and Tempier, 1991). The anchoring of the mental health system in the community has been extolled as an empowering strategy for a stigmatized and marginalized population (e.g., Vega and Murphy, 1990); as an efficient and economical means of dealing with chronic illness (e.g., Leff, 1990); as a professional, reasoned and assertive response to community needs (e.g., Bachrach, 1991); or as part of a larger strategy to incite individuals and families to rely less on costly public services and more on their own resources (e.g., Robert, 1989). Given the segmentation of contemporary Western societies, all of these objectives may co-exist, and not always harmoniously, as each is likely to be defended by a different social group. This is why authors, who themselves represent different professional and social groups, have tended to identify "barriers" or "impediments" to change and innovation in the mental health field in terms of political, professional and administrative "resistance" (e.g., Marks and Scott, eds., 1990).

This paper argues that underlying "resistance", the basic obstacle to effective transformation of mental health systems is the lack of consensus regarding what constitutes a community-based system. Within a single society the various agencies, organizations, professions and social groups implicated in the mental health field in one way or another all claim to favour the transition to a community-based system, and to incorporate a community-oriented approach into their programs. Simultaneously, they pursue contradicting ends and develop competing strategies. It is *not* the aim of this paper to lay out a series of characteristics around which a consensus on the meaning of a community-based mental health system might be built. On the contrary, the premise is that real change can be facilitated if differences and contradictions are highlighted rather than obscured.

The paper begins by addressing the problem of obscurity in the community discourse that presently dominates the mental health domain. The problem is related not only to the lack of a single understanding of what the word "community" might mean — sociologists are themselves in disagreement — but also to the fact that different social actors within the field of mental health policy and intervention use the term to refer to very different objectives and strategies. Next, drawing on the empirical literature on community mental health, and in particular on the Quebec case,[2] a survey of assorted strategies associated with the community discourse will be presented. Finally, three examples from Quebec's experience in implementing its mental health policy will be discussed with a view to demonstrating the variety of models that can emerge on the basis of what might appear to be a relatively unified discourse.

The Quebec case is particularly interesting because an official policy adopted in 1989 is ostensibly aimed at reorienting the mental health system away from institutions and purely medical intervention, towards greater community involvement in regional planning, system organization and direct intervention. However, since this policy is highly decentralized, with regions and even sub-regions responsible, to various degrees, for developing mental health systems that correspond to the general orientations of the policy, considerable diversity can be found from one district to another.

"Community" as a Discursive Strategy

Discursive strategies are the chosen terms used by collective social actors to give meaning to their actions (Giddens, 1984). Like C. Wright Mills' "vocabularies of motive" (Mills, 1967), the expression suggests the verbal arbitrariness of the ways in which we define and justify what we do, which change according to shifting social and political positions and environments. In other words, different times and contexts provide different discourses

for social actors to draw upon in their relations with others, and in their struggles to gain or maintain legitimacy and dominance (Hindess, 1982).

The community discourse refers to a shared vocabulary in the mental health field denoting a turning away from institutionally-based approaches for dealing with people with mental health problems. Indeed, it is a discourse coming to dominate mental health circles in the West, rapidly taking over from the once-dominant medical discourse which is now in relative disfavour, at least in the policy domain.[3] However, this commonly-valued set of terms is deployed in different ways by social actors for whom it has different meanings. Thus, the deployment of the discourse is strategic: it is chosen as the currently-legitimate language to defend all positions and objectives. As an apparent commonality in a fragmented and diversified field of social action, the discourse in itself is void of any specific meaning. Like the concept of "national interest", everyone is in favour of it but none would necessarily define it in the same way. The meaning is constituted by the actors who use it.

By providing an alternative to previously dominant (medical) ways of thinking about intervention in the mental health domain, the community discourse has provoked considerable policy action. Yet the non-essential character of a community orientation in mental health is evident in the fact that this activity has had little in common from society to society, other than to justify and support policies of deinstitutionalization.[4] For example, community mental health centres and community support systems in the U.S. (Grusky et al., 1985), community care in Britain, *psychiatrie du secteur* in France (Corin et al., 1984) and the *psychiatria democratia* movement in Italy (Lovell, 1986) are very different strategies though each relies heavily on a community discourse. Furthermore, community-oriented activity itself has generated conflicting objectives and perspectives *within* societies. For example, in the U.S., the psychosocial rehabilitation movement challenges the medically-oriented practices still dominant in many community mental health centres, but is itself challenged by a strong consumer movement in mental health which places the rights, dignity and autonomy of the individual with mental health problems at the forefront of its value system. In sum, the community discourse in mental health is neither consistent nor unified.

This blurring is particularly well-illustrated in Quebec's official mental health policy (1989). For example, the single term "community resources" is used to refer to a wide variety of organization types and programs, and thus to obscure important distinctions between them. Autonomous voluntary associations promoting an anti-psychiatry approach and defending consumer rights may be lumped in with organizations contracting with hospitals to provide specialized out-patient services. Both are indeed community

resources in so far as the community can loosely be considered an environment outside the "total institution", to use Goffman's (1961) term, but they have nothing else in common, and respond to the needs of different populations in very different ways (White and Mercier, 1991). To discursively dismiss these differences can have an important impact on the orientation of emerging mental health systems.

To highlight the different referents of the community discourse in mental health, I am inspired by three meanings associated with the concept of community in the sociological literature: (1) with respect to the **planning** of community mental health systems, the concept of community as *locality* is most often intended; (2) to distinguish between a **service delivery system** organized around associations that are self-generating and emerge in response to perceived needs, from those which are mandated, such as medical facilities and social services agencies, community is taken to refer to *civil society* as opposed to the state; and finally (3) forms of **practice** that place a greater emphasis on therapeutic social relations such as mutual help and caring between peers draw on a sense of community as *gemeinschaft* — a group of people connected by a common sense of identity and strong affective ties (Tonnies, 1988; Weber, 1978).

In the following sections, each of these dimensions of the community discourse is taken up in turn. The aim is to demonstrate that, not only can the community discourse be used to refer to different ways of planning, organizing or practicing mental health intervention, but even within each of these spheres, different and often opposing meanings are evoked to justify a wide variety strategies. Furthermore, on the basis of the literature on community practices in mental health, as well as examples from the Quebec case, it becomes evident that a particular orientation in any one sphere does not necessarily imply a consistent orientation along the others. This results in the emergence of ambiguous systems which appear to be community-oriented in some ways, while opposed to a community orientation in others.

Community as Locality: Decentralization of The Planning Process

In much of the literature on the establishment of community-based mental health policies, the planning process is considered to be the prime determinant of success.[5] In Britain, the significance of community planning has been highlighted in a study of a variety of innovative systems. An audit commission of the Department of Health and Social Security concluded that all successful community-based systems had come about as the result of "a radical departure from the generally accepted ways of doing things" (DHSS, 1986, cited in Carrier, 1990:133). Specifically, planning was the responsibility of a *locally* integrated body, with its focus the *local* neighbourhood, and

in which *local* leadership was strong and committed. The successful planning body consisted of both public and voluntary organizations, and no one professional group dominated. Thus, from this point of view, exclusively community-based organizations and gemeinschaft-like forms of intervention were not considered as salient to the successful community mental health system as was the planning process itself.

On the other hand, local planning has sometimes been considered detrimental to the development of community mental health systems. For example, Test and Scott (1990) point out that in the American context, the systematic implementation of community support systems is stymied by barriers to *comprehensive planning*, such as diversified loci of responsibility (federal, state and local government programs superimposed on private and community services). Likewise, in New South Wales, Australia, an argument in favour of centralized planning rests on the premise that if left to local leaders, the community model of service delivery favoured by policymakers risks being distorted or lost altogether. Local autonomy, flexibility and input are not considered essential ingredients for a community mental health system, according to a leading professional advisor and planning agent in New South Wales:

> Although we tried to ensure conformity by having the new services in an area undergo training with the best of the established services, ultimately the local management have been free to make their own adaptations. Those services which varied the most from the original model were also those which had leaders least committed to the model, and the latter factor seemed more important in accounting for poor performance. (Hoult, 1990:54–55)

From another perspective, centralized, comprehensive planning would appear to be antithetical to the development of a community-based support system since it would impose alien and universal organizational forms on a locality regardless of its own history and dynamics. Furthermore, the presence of a "community representative" on a central planning body would be insufficient to generate a community-based system, since the community-as-locality is not homogeneous, but rather a meeting place for diverse social agents striving to impose their own agendas (Klein, 1989). This suggests that local planning is not only a question of local consultation, but of *participation,* that is, of social relations within the planning body, and the extent to which this body represents the diversity of the community. Figure 1 illustrates some of the characteristics that might apply to a planning process based not only *on*, but also *in* the community, as well as their institututionally-based opposites. Both in theory and in reality, many community-based mental health systems may be described as floating along

Figure 1
Community as Locality:
Continua with respect to planning

community-based planning		**institutionally-based planning**
Neighbourhood targeted	⟷	Society targeted
Local body	⟷	Central body
Bottom-up	⟷	Top-down
Diverse actors	⟷	Monopoly

these continua, advocating or demonstrating some community and some institutional traits.

Quebec's recently adopted mental health policy is an example: although devoting considerable attention to the planning process, which is equivocally regionalized, it does not decentralize planning to the local level. Regions Councils, which may be responsible for territories having a population of over three million, or cover areas well over 50,000 sq. km., are the new, central decision-makers. Yet policy guidelines are produced at the Ministerial level, while Regional Health and Social Service Councils are really charged only with implementing this policy in their territories. The majority of regional plans submitted for approval to the Ministry were either rejected or modified. If this decentralization is hardly radical, the Regional Councils themselves differ significantly in the extent and manner in which they delegate planning to smaller, local bodies.

Divergent interests within localities (however large or small) are, however, recognized and legitimated in Quebec's policy. Each Regional Council must be advised by a tri-partite committee drawn from (a) public health and social service establishments in the region, (b) voluntary organizations in mental health operating in the region, and (c) other interested parties in the region (e.g., school boards, police, welfare agents, drug abuse programs, women's shelters, etc.). Some regions have duplicated these tri-partite committees at the local level, although the degree of autonomy at that level is most often restricted to setting service priorities. In one region, where five years prior to the adoption of the provincial policy, local advisory committees were granted the power to recommend the financing of particular local organizations to the Regional Council, the level of local autonomy has actually been reduced since the implementation of the policy.

The principal effects of Quebec's planning strategy have been (a) the breaking of the psychiatric and mental health professional monopoly over decision-making in the mental health domain, and (b) the emergence of very different organizational plans for service delivery in different regions. This last result is a reflection not only of different administrative strategies on the

part of Regional Councils, and the different means at their disposal (some being more financially and organizationally developed than others), but also of the different dynamics evolving within the tri-partite committees, where the configuration of actors and the power relations between them vary from region to region. Thus, in a densely populated region, where 90% of the province's psychiatrists work, the planning process is more decentralized, and is subject to different dynamics than a sparsely populated region where there are no psychiatric hospitals, psychiatrists are scarce and community groups are relatively passive. These same dissimilarities between regions also imply a different balance of power between the Regional Councils and the central Ministry, accounting for more or less regional autonomy.

Community as Civil Society: State versus Non-State Organizations in Service Delivery

If at the point of planning, "community" tends to refer to the local and its relation to the centre, in the context of the organization of service delivery, the term takes on a different sense. This is perhaps best represented by the distinction between the concepts of "catchment area" on the one hand, and "natural milieu" on the other (Hunter and Riger, 1986). Catchment area, an administrative term, denotes the territory from which an institution draws its clientele, the territory that it is mandated to cover. The "natural milieu", on the other hand, is not primarily concerned with geographic boundaries, though they may exist in some vague manner, and does not depend on mandates from any level of government. Rather, the natural milieu constitutes an "organic" environment which, harking back to the analyses of the Chicago School, has a self-generating existence and takes a form particular to the social groups and relations that compose it.

It is in this sense that "community" takes on the meaning of civil society in the context of service delivery. Civil society comprises all those associations and organizations that evolve more or less spontaneously in the society as opposed to being directly controlled or mandated by the state. Civil society is that arena where members of a community associate to create their own particularized social organization. Thus, Sévigny explains the significance of such community-embedded services in cultural terms:

> It is in this *community* that the person is able to fit into a social universe where adaptation, integration and normalcy are not inevitably tied to the dominant norms of rationality, functionality, profitability: this adaptation rather takes place within the framework of a local culture, where the values, expectations, modes of living allow the person to attribute a meaning — a positive meaning — to his or her existence and experience. (Sévigny, 1991:31)

Sévigny is contrasting the indigenous and culturally accessible to the rational and bureaucratic, the familiar to the alien, the particular to the universal and uniform. Segal et al. make a somewhat similar point:

> In an in-service training session we conducted for community care workers, one social worker told us: "Many of the good facilities won't take 'bad' clients. We, therefore, put them in 'bad' facilities, where they seem to do reasonably well . . . ". Following from this observation, it may be important to change perceptions of what is meant by "bad" facilities. The notion that model facilities are those located in white middle-class neighbourhoods and ones that are sparkling examples of hygiene and efficiency, seems fundamentally misleading. (Segal et al., 1989:62)

These researchers found that social integration for people with severe and chronic mental health problems tends to be most successful when they share key socio-economic, demographic, ethnic and other characteristics with their social and living environment. This suggests that, first, removal of people with mental health problems from their natural milieu to more "salubrious" surroundings may be counterproductive, and second, that the imposition of certain universal norms for service delivery (such as a professionally qualified staff or a given staff-user ratio), which usually accompany mandates, may actually counter some of the possible advantages to incorporating indigenous resources into a system, "warts and all".

The "natural milieu" consists not only of mental health resources, but of all formal and informal, private and public resources available to everyone in the locality. It is, by definition, a "loosely coupled" system (Weick, 1976), in which coordination is haphazard or absent, though various informal relations of cooperation and collaboration — as well as conflict and mutual disregard — may evolve amongst the actors involved. Bachrach (1982) has described this as an "organic" mental health system, which she distinguishes from the "synthetic" system. The "synthetic" system is a bounded and coordinated system of resources which may take the form of a unitary institution or of a combination of service organizations, such as the Community Support Systems in the U.S. whose collective mandate is to meet the needs of people with mental health problems within a given territory. The local community has been targeted in the planning process, but services are designed and provided — or at least coordinated — by professionals associated with a public institution such as a social service agency or community mental health centre (Grusky et al., 1985).

In contrast, the "organic" system is an open and all-inclusive network of resources, loosely encompassing all local services available in the area in mental health and other domains, including personal networks. Thinking in terms of the organic system means recognizing that people with mental health problems benefit from a whole range of local associations and

organizations that go well beyond those specifically set up and intended for their use. Most resources of the organic system emerge within a community on the basis of local people developing responses to needs manifested at the community level. Thus it might become clear that in certain localities, respite for families of adult children with serious mental health problems living at home is a priority, and parents' self-help groups will emerge. In another neighbourhood, families may be far less present, and self-help groups for ex-patients themselves may be more prevalent than those for parents and family members. Clubs or other organizations offering instrumental help in finding lodging, dealing with the welfare bureaucracy and so on might also be more likely to emerge in some localities than in others.

Mental health systems based primarily on statutory services available in public medical and social work agencies have neither the flexibility nor the receptiveness to communities to respond in this fashion. For example, "ethnic"-oriented statutory services rarely involve more than a multilingual staff with some training in "cultural sensitivity", but otherwise correspond to the alien norms of the public institution. They cannot be compared to the traditional and alternative forms of treatment and help offered and used, for example, by various ethnic minorities in the society.

Yet synthetic systems, participation in which is controlled through individualized service plans and case management, are currently considered by some to be the ideal model for service delivery in the community. One example is the Alternatives to Mental Hospital Care in Madison, Wisconsin (Stein and Test, 1980), a highly professionalized and structured program that assertively superimposes a treatment plan on the person's community living experience, and monitors not only the person, but his or her family and workplace as well. In the view of Test and Scott,

> a comprehensive community support system must be tightly integrated and coordinated, with responsibility clearly fixed in order to ensure continuity of service and to avoid confusion and fragmentation. (Test and Scott, 1990:13)

While such a system appears to be relatively successful in maintaining severely and chronically troubled people outside of the institution, critics argue that such strategies do so by recreating the conditions of the institution in the community (Corin and Harnois, 1990). Indeed, evaluations of aggressive case management programs suggest that they augment the use of services (Intagliata, 1982) and thus may be more successful at integrating people into the service system, than integrating them into the natural milieu (White, 1992). Other studies have concluded that continuity of care may be less a question of tight coordination of services and intensive monitoring, and more a question of the existence of a wide variety of resources that are both easily accessible by the person living in the community, and

appropriate to their needs (Solomon et al., 1986). Still, community mental health systems are as likely to tend towards the "institutionally-based" pole of the service delivery continua illustrated in Figure 2 as towards the "community-based" pole.

Figure 2
Community as Civil Society:
Continua with respect to
the organization of service delivery

community-based service delivery		**institutionally-based service delivery**
Particular services	⟷	Universal services
Indigenous organizations	⟷	Alien establishments
"Organic" system	⟷	"Synthetic" system
Loosely coupled	⟷	Coordinated/integrated

Ultimately, the boundary between mandated systems and systems embedded in civil society is a fluid one, and nowhere is this more clear than in the Quebec case. Quebec's mental health policy has placed considerable emphasis on the direct participation of indigenous resources — as opposed to public establishments — in service delivery, and this recognition of the role and place of voluntary organizations is not strictly a cost-saving strategy for the government. It has emerged from a long and contentious social debate related to Quebec's history of top-down social development.

During Quebec's Quiet Revolution of the 1970s, the community discourse permeated governmental reforms in the area of health and welfare. By coopting popular clinics and voluntary organizations that had sprouted in various urban neighbourhoods and establishing in their place, over time, more than 150 *public* local community health and social service centres (CLSCs) across the province, the state outdid the community in its "community-ness". CLSCs were initially supposed to reflect the unique characteristics of the neighbourhood in which they were installed, but as public establishments, their growing bureaucratization, professionalization and uniformity contrasted with the cultural embeddedness, flexibility and innovation typical of the local voluntary organizations they tried to emulate (Godbout and Guay, 1989).

Throughout the 1980s, debates raged over the differences between resources established *in* the community by hospitals, social service agencies and other public establishments, and alternatives that were *of* the community, developed by citizens rather than government (White and Mercier, 1989, 1991). When fiscal constraints finally curbed the Quebec government's enthusiasm with its own public network of unionized establishments,

interest in incorporating voluntary organizations into the service system escalated. It is in this context that the primacy of the "natural milieu" in mental health care became a policy idiom in Quebec (Boudreau, 1987). In fact, Quebec's official mental health policy states:

> The contribution of organizations originating in the community is particularly evident in mental health. To promote community tenure and social integration, it is essential to support these groups and to welcome the solutions they propose. . . The Minister recognizes as community organizations all those groups originating in the community that engage either in voluntary action or non-profit activities in the domain . . . For the purposes of this recognition, the ministry establishes [the following] conditions:
>
> . . .
>
> - the organization is autonomous in its orientation and practices, and its board of directors is composed of service users and people from the community milieu in the majority;
> - community support, financial or otherwise, contributes in part to its operation. (Quebec, Ministère de la santé et des services sociaux, 1989:49)

It is expected that these provisions would have an important impact on emerging mental health systems in the various regions of Quebec, particularly because of the parity accorded such indigenous organizations in the regional advisory tri-partite committees. Since community organizations adhering to this definition make up one third of each committee, while public psychiatric and social work establishments together make up only one other third, there is the potential for a shift in the power balance between statutory, state-mandated establishments and autonomous community organizations. This potential is realized to different degrees in different regions, depending upon (1) the extent of influence that the tri-partite committees really have on each Regional Council's organizational plan, (2) the configuration of public and community resources within the region, and thus the relative strength of local community and institutional leadership, and (3) the particular strategies adopted by community and public organization representatives in each region.

In short, Quebec's system is community-based to the extent that it actively encourages the participation of voluntary associations in the delivery of services. It goes so far as to reorganize the structure of relations between community and public service providers, assigning each equal status in the planning process and assuring administrative independence and autonomy of orientation to alternative resources. However, even greater emphasis is placed on promoting individual and family responsibility. As Boudreau (1987) has argued, this apparent confidence in the capacity of the private domain to take over where the state fears to tread may be misplaced.

The Community Component in Practice: Shared Meaning versus Expertise and Control

If service delivery refers to the organizational characteristics of a mental health system, practice refers to the clinical characteristics, or the relation between practitioners or helpers and service users. In Hunter and Riger's (1986) description of community-based principles, the shift from "catchment area" to "natural milieu" in the organization of service delivery is matched, in the realm of practice, by a shift from professional to natural helpers. Natural helpers would include those whose credentials lie more in the area of experience and sensitivity than in formal training, those with whom there are shared meanings in a *Gemeinschaft*-like context.

The epistemology underpinning this shift argues that the knowledge base used to make clinical decisions in mental health should itself be "community-based" (Vega and Murphy, 1990). According to this philosophy, since both the etiology and symptoms of mental health problems are inextricably tied to cultural and social variables (e.g., beliefs, values, relationships, expectations, social norms, life chances, lifestyles), sensitivity to these phenomena is ostensibly more essential to the helping relation than are standardized diagnostic and treatment procedures typical of professional intervention, including the "needs assessments" carried out by social workers.

Indeed, from this perspective, professionalism *per se* implies a controlling relationship, namely, exclusive control over a stock of knowledge and therefore, control over the object of this knowledge (White, 1990). It further implies a distancing from the object of intervention, an admonition not to become "involved". In contrast, community approaches generally focus on *empowerment* as opposed to control, and on sharing and mutual support as opposed to detachment (Chamberlain, 1978). Self-help societies, group therapies and communal enterprises tend to replace specialized services focusing on "deficits" identified by experts. The "club" model of intervention, such as New York's Fountain House, epitomizes this approach.

But not all community-based models of care embrace this approach. In contrast to the consumer-centred empowerment model, Stein and Test (1980), for example, argue that community care depends upon aggressive professional intervention. In their model,

> Members of the core team plan and monitor treatment plans for each patient [sic] and are also responsible for delivering most of the required services themselves . . . For example, members of the team might contact employers on a daily basis to ensure that certain patients have shown up for work, and visit the patients' place of residence to determine if problems are occurring. Each patient is closely monitored to check that they are taking medication, showing up for work, functioning adequately at home and elsewhere. (Test and Scott, 1990:14)

Figure 3
Community as Gemeinschaft:
Continua with respect to intervention practices

community-based practices		**institutionally-based practices**
Centred on Life-world	⟷	Centred on Service system
Experiencial knowledge base	⟷	Scientific knowledge base
Consumer control	⟷	Professional control
Objective: Empowerment	⟷	Objective: Management

Evidently, models of practice within community-based systems of care can differ profoundly. Depending on the extent to which either the professional or user perspective dominates the system, interventions may be more or less assertive, and the prerogatives of expertise may hold more or less weight than the preferences and personal autonomy of the individual. The tendency to treat natural helpers as clients rather than partners and peers is common in the domains of youth protection, care for the elderly and care for people with mental health problems (White and Jutras, 1990). The assertive professional model of community care, regardless of whether it adheres to an empowerment discourse, in fact adopts an attitude of protection and control vis-à-vis the "patient". Overall, the relation between professionals and natural helpers—be they family or peers—will depend on the level of authority or legitimate power that professionals enjoy within the system. Figure 3 illustrates some of these contrasting tendencies.

Amongst the obstacles to implementing such assertively professionalized community programs, cited by Test and Scott as well as many others in various Western countries (Knapp, 1990; Rubin, 1990; Marmor and Gill, 1990) is the ubiquitous governmental search for fiscally advantageous solutions to health care problems. Recent studies of labour-intensive, assertive case management have indicated that this approach is associated with higher use of psychiatric services and greater numbers of hospitalizations than routine after-care (Curtis et al., 1992), suggesting that professionalized community intervention may *increase* the costs of managing of people with mental health problems in the community. If, on the one hand, greater use of services may or may not lead to better quality of life for service users, on the other hand, recourse to natural helpers and other non-professionals is fast becoming the preferred strategy amongst policy-makers, bolstered by the apparent inefficacy and high cost of highly professional intervention.

In Quebec's mental health policy, the call for a partnership between community and the state in mental health care emphasizes the primary role of the individual, families and friends in taking responsibility for meeting needs. The role of the public system should ostensibly be to complement

private (as in family) and community resources (Quebec, 1989).[6] Boudreau (1987) has called this a "unique blend of individualism and collectivism" that distinctly differs from the social democratic logic that preceded it in the 1970s. She points out that "the language of citizens' advocates and self-help groups has become the preferred language of policy-influencers within the Ministry" (1987:39).

Three years after this observation, the first implementation phase of Quebec's official mental health policy provided new funding *only* for self-help groups, consumer advocacy, family respite and, a year later, for prevention. No money at all was targeted for community-based service programs *per se* (such as housing or therapy programs). This move which ostensibly strengthens and legitimates individual, family and community responsibility may have little to do with a particular philosophy of mental health *practice*, and more to do with political philosophy: the desire to reduce government responsibility. This is a particularly acute objective in Quebec where Quiet Revolution policies tended to present the state as a magnanimous provider, engendering high expectations on the part of the population.

Contrasting Examples of Community-Based Systems

Within the context of Quebec's 1989 mental health policy, diverse models of mental health systems have already been generated. Differences are evident in the planning strategies adopted by different Regional Councils, including the extent to which they delegate some autonomous control to local districts, in the organization of service delivery at the local level, and in the dominant intervention models that emerge at that level.

Three local models will be presented here, including two from within the same region. All may be considered community-based systems in the sense that none revolves around a psychiatric institution (though each involves a general hospital with a psychiatric department) and all entail a range of non-institutional resources available within the locality. Yet none are similar: each may be seen to represent a different set of points on the various planning, service delivery and practice continua illustrated in Figures 1 to 3. It is clear that, despite the distinctly community-oriented guidelines of Quebec's policy in the areas of planning, service delivery and practice, different dimensions of "community-ness" have emerged as dominant in different districts. We attribute these differences to the social actors that are present and the social dynamics that animate the different districts, more than to marked differences in the clientele or needs.

Suburbia: A Technocratic Community-Based Model

One district in which a professional, assertive community-based model has emerged in the past five years is a vast suburban area adjacent to the

Metropolis. We refer to this as a "technocratic" model because the dominant influence has been that of the local planning and coordinating committee, mandated by the metropolitan Regional Council in all six of its mental health districts. In the case of Suburbia, this advisory committee has reshaped the local system despite strong opposition in the early stages by local mental health activists.

If Suburbia was once a remote series of bedroom communities serving the Metropolis, its industrial base has greatly expanded over the last two decades, especially in high-tech areas such as telecommunications and pharmaceuticals. This has resulted in it being one of the fastest growing districts in the province. Although only slightly more than half of the population has English as their mother tongue, this is generally considered an anglophone bastion in Quebec, which affords a certain identity to the district. Suburbia is solidly middle class, and on socio-economic variables, it scores highest amongst the Metropolis' six mental health districts due to the near-absence of poorer neighbourhoods.

Public health and social service resources have not kept up with the pace of growth in Suburbia. There is one small general hospital with no links to teaching institutions, its small psychiatric department staffed by a few part-time psychiatrists and a social work team. Two CLSCs are situated in the area, though one is so new that the range of primary health and social services it offers is still limited. Given the geographical expanse of the district and limited public transportation, this means that local services are scarce and can be difficult to access.

Suburbia has always boasted an active civic community, though the indigenous voluntary associations have tended to be of a traditional type: philanthropic and service organizations such as the Optimists and Lions Club, civic groups and "womens' auxiliaries" associated with churches or other institutions. In the domain of mental health, community leaders in this middle-class, residential area have been mainly the parents of adult children diagnosed with psychiatric problems, and have been active in both advocacy and volunteer services. One CLSC opened a small, part-time "club" with social integration and rehabilitation activities in the mid-1970s. In the absence of strong professional and institutional leadership in the district, parents' groups have been aggressive in their criticism of the local psychiatric department and vocal in their demands for more and better "community" services — meaning services *in* and *for* the community.

A highly decentralized planning process for the development of mental health resources was put in place by the Metropolitan Regional Council in 1984, and has had an important impact on the evolution of the mental health system in Suburbia. Each district was assigned a coordinator to consolidate and develop local community mental health resources. Coordinators were

to nominate a local advisory committee that included representatives of the major public health and social service establishments in the area, as well as at least one representative of the "community". Although there was considerable difficulty finding a coordinator for Suburbia who would be acceptable to the community, the job was finally given to a community organizer from one of the local CLSCs. With his full approval, the advisory committee voted early on to equalize its community and public establishment representation in light of the strong presence of community leaders in the mental health field.

Community representatives on this committee consisted of parents and volunteers nominated by the local Association for Psychiatric Alternatives, established by the local leadership to develop strategy regarding the new, decentralized mental health planning process in the Metropolitan Region. Most local mental health advocates and promoters sitting in the Association did not directly participate in the advisory committee, preferring to lobby it from the outside.[7] Although the committee operated within parameters set by the Regional Council, and although it officially functioned only in an advisory capacity, its recommendations with respect to the consolidation of existing organizations, the creation of new resources and the distribution of new funds were consistently respected by the Regional Council.

The configuration of the mental health system that has emerged in this district over the last several years represents a notable change from what had been present before the local planning process began. First, if there had been little more than the local hospital and one or two voluntary organizations, there are now a variety of psychosocial rehabilitation day programs, community follow-up, supervised housing and a crisis centre, all autonomous non-profit organizations. Second, although previously existing voluntary organizations have been expanded, the new organizations established tend to be of a type very different than what was traditional to the community. They are more professionally structured in their philosophy and programming, which tends to be based on the latest trends in assertive community intervention. These differences have caused some friction between the traditional local leaders in the mental health domain, and those who gained their leadership status principally through their active participation in the advisory committee, and now sit on the boards of directors of the various new organizations they established.

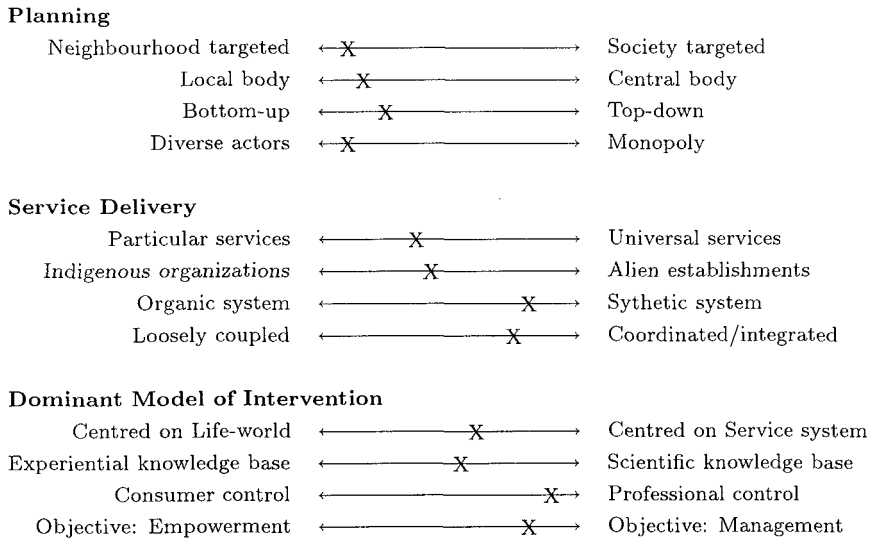
However, as the original community resources have been consolidated through the funding of new programs, orchestrated by the local advisory committee, they have begun to move beyond the traditions of their original leaders, and have taken on more of the characteristics of the new organizations. While still involving volunteers, they too have hired staff with professional training, and have structured and diversified their approaches

and programs. Thus, if the mental health system has retained only a touch of the district's original civic action traditions, the "new" style has not been entirely imposed from the outside. Rather, it has evolved within the community, under community leadership, with the injection of funds into the district and the immediate presence of a planning body structuring the disbursement of those funds.

While both planning and service delivery appear to be firmly ensconced in the community, the indigenous intervention traditions of Suburbia are rapidly fading. Once based on family, volunteers and a "natural helper" philosophy, the dominant model of community practice is becoming more and more centred on assertive, professional programming. In fact, the community-based planning strategy has had the added effect of inciting more active involvement on the part of local public/institutional resources, in particular the social service staff in the psychiatric unit of the general hospital. One result is that the most recent program added to the system is located in a CLSC rather than a voluntary organization, and functions in coalition with nursing staff from the hospital's psychiatric unit, as well as several community organizations. Perhaps this trend should not be seen as a diversion from earlier values; if traditional community organizations in Suburbia were based on volunteers and natural helpers, it was because the local leadership believed that this was the normal role of civic action in the society, complementary to professional expertise. A stronger professional presence had always been seen as an essential counterpoint to community practices.

To summarize (see Figure 4), local planning in Suburbia was a relative success thanks to an effective and respected decentralization of the planning process by the Metropolitan Regional Council. However, there have been some changes since the adoption of the province-wide policy in 1989: local advisory committees have lost many of their responsibilities, especially with respect to attributing funds. Their role is now restricted to one of local coordination according to the regional plan. Still, service delivery remains embedded to a large extent in local, non statutory organizations. Traditional community resources have been consolidated and expanded. The dominant practice model, however, has shifted from natural helpers coupled with advocacy for better professional services, to a gradual professionalization of community-based services. Not only are new organizations oriented towards highly structured, professional community intervention, but old organizations are gradually professionalizing their programs with the funds they have received through the local committee. Furthermore, as this trend continues, public institutions appear to be gaining ground as providers of community care.

Figure 4
A Technocratic Community-Based Model



Cityfringe: An Alternative Community-Based Model

The critical ideology known as anti-psychiatry (Szasz, 1961; Cooper, 1967) made considerable inroads as an alternative philosophy in the mental health domain in Quebec at the beginning of the late 1970s, specifically in reaction to early deinstitutionalization programs. The medication of mental patients released from the asylum into the community did not suffice to ease their integration, and no public non-medical services for this population were available. The Quebec Association of Alternative Mental Health Resources was formed in 1982 to reinforce and promote user-centred organizations offering independent, critical programs aimed at weaning former patients from the psychiatric system, and helping them to gain a sense of dignity, autonomy and psychosocial support (White and Mercier, 1989, 1991). When we refer to an alternative system, we are referring to a model in which this philosophy of intervention is dominant.

Cityfringe, like Suburbia, is essentially a suburb of the Metropolis; it does not fall within the boundaries of the Metropolitan region, however, and its own Outskirts Regional Council functions quite differently from that of the Metropolitan Region. With respect to mental health resources relative to its population, the urban and semi-urban Outskirts Region is amongst the poorest in Quebec — one of the only regions with no psychiatric institution and relatively few hospitals. Its Regional Council has vigorously espoused a pro-community discourse in the domain of mental health since the early

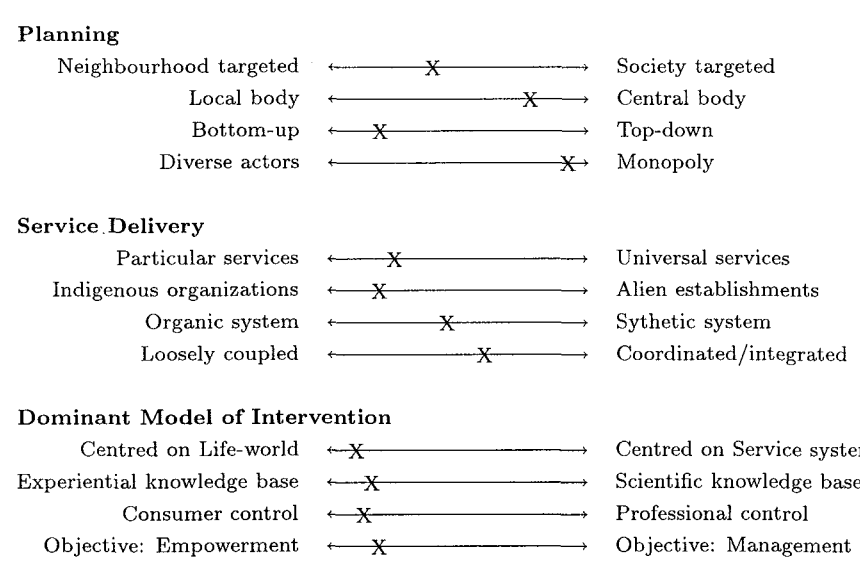
1980s, and, though working with limited funds, indeed helped to create a number of alternative organizations. Furthermore, this small Regional Council, unlike that of a major metropolitan area, is in a constant struggle for autonomy vis-à-vis the central Ministry, so that maintaining its own central authority is a far greater priority than delegating authority to local districts. Although it has set up various local consultative bodies over the years in its nine districts, their mandates have been vague and limited, and their decisions not always respected. Informal consultation with local leaders often takes precedence.

The district of Cityfringe is partly suburb and partly a semi-urban scattering of small towns. Although adjacent to the Metropolis, it is connected to the city by a single bridge, constructed only in the 1960s. Its history of forced separation from the Metropolis next door, and its bordering on a Native Reserve, have contributed to a relatively independent and cohesive community identity. Its population is for the most part middle class industrial and service workers, young and rapidly increasing. The major industries are heavy manufacturing and food processing, with retail business and services employing a large proportion of the population as well. This district is less socio-economically homogeneous than Suburbia.

Until 1988, there was no hospital within the district's current boundaries. Therefore, filling a leadership role in the health and social service domain was a well-established and influential CLSC, one that had been in place since the early 1970s. This CLSC had been an important partner in the militant community activism that had animated the district (and other urban working class districts) during that decade, for example, in the areas of cooperative daycare and housing. The CLSC was also active, in the 1980s, in lobbying the Ministry for the establishment of a local general hospital, and ultimately participated in planning and programming for the psychiatric unit once the hospital's construction was approved. This unit is still relatively uninfluential with respect to developments in the mental health field in Cityfringe because of its status as a "newcomer" in the domain.

Local leadership in the mental health domain is dominated by the district's traditional community activists who favour an anti-psychiatry, anti-institutional ideology. The local CLSC played an important role in providing community support for people with mental health problems, especially in the absence of a local hospital. Following the anti-establishment pattern of most of Quebec's early CLSCs (those established in the 1970s), its own perspective was decidedly non-medical and user-centred. Part of its mandate was to encourage community development and it did this by lending considerable strategic support to local civic leaders interested in mental health. Some of the local leaders from Cityfringe have gone on to become provincial leaders in the Quebec Association of Alternative Men-

Figure 5
An Alternative Community-Based Model



tal Health Resources and in the Quebec Association for the Rights of the "Psychiatrized".

With respect to mental health planning, local committees set up in Cityfringe by the Regional Council have been quite ineffective, either dominated or skirted by the militant, local community leadership. However, in contrast to the Metropolis, funds for the development of mental health care in general are more difficult to come by in the Outskirts Region, and procuring any development funds at all requires considerable strategy. Local leaders in Cityfringe, in alliance with the CLSC, through lobbying and more direct political action (e.g., media spectacles) aimed at their Regional Council and at the Ministry, have not only been able to secure considerable development funds for their district, but have also been able to block the emergence of new community resources that run counter to their own philosophy. The upshot is that almost all community mental health resources in this district, including housing, a day centre and a crisis centre, are concentrated in a single, sprawling voluntary organization.

At some points in its history, this voluntary organization has been labelled a "bad" facility, in the sense referred to by Segal et al (1989): complaints have occasionally been made regarding hygiene and supervision of residents, and the local social service agency has refused to refer clients. It is unclear whether this boycott exists only because of disapproval of conditions at the resource that do not meet norms, or because of the

therapeutic orientation which aims to help people manage their problems without medication. This resource continues to receive new funding and despite occasional crises, continues to thrive. The only other organizations that have emerged in Cityfringe are two self-help groups, both sponsored by this dominant organization in their bid for funds from the Regional Council.

This alternative-dominated service delivery strategy ensures that the principal intervention approach is decidedly user-centred. In the leading resource, the worker-user ratio is low. It employs few if any professionals, and its own users are likely to be intensely involved in its operations. The recent hiring of a professional coordinator (related to an important expansion) provoked the resignation of most other staff members, but it is not likely that this crisis presages a move towards assertive professionalization, since users still dominate the board of directors. Furthermore, consumer-power is becoming more and more prominent in this district and, under Cityfringe's leadership, in the region as a whole. For example, the local self-help groups promote a philosophy in which self-help goes considerably beyond informal mutual support, to the provision of diverse services in a user-controlled environment. This broad definition of self-help has now been adopted by the regional tri-partite committee, despite serious misgivings on the part of the Regional Council.

In short, despite the lack of a structured local planning committee and the centralizing tendencies of the Regional Council, local leadership has managed to shape the mental health system in Cityfringe, mainly through informal channels and political strategies. However, unlike the caes of Suburbia, service delivery and practice models have *evolved* very little, besides some growth in the number and types of services provided. In the absence of structured local planning that might have empowered weaker local actors (such as the new psychiatric unit or promoters of a structured rehabilitation program) and forced compromises, as was the case in Suburbia, the traditional anti-psychiatry leadership has been able to maintain a near monopoly over service delivery and the philosophy of mental health intervention, as Figure 5 indicates. Change in Cityfringe has been more at the level of quantity than quality.

Smalltown: An Institutional Community-Based Model

When public institutions such as psychiatric hospitals, psychiatric units and social service agencies turn towards providing services *in* the community, in facilities located outside their walls, they are still usually bound by professional perspectives and practices. In this case, the organization of service delivery may change, but the mode of intervention may not. Furthermore, since such facilities are created from budgets controlled by the institution, planning is carried out by resident staff according their evaluations of the

needs of their clients or patients. Although the district of Smalltown is located in the same region as the militantly alternative Cityfringe, and falls under the authority of the same Regional Council, it has developed a mental health system that we would designate as institutional.

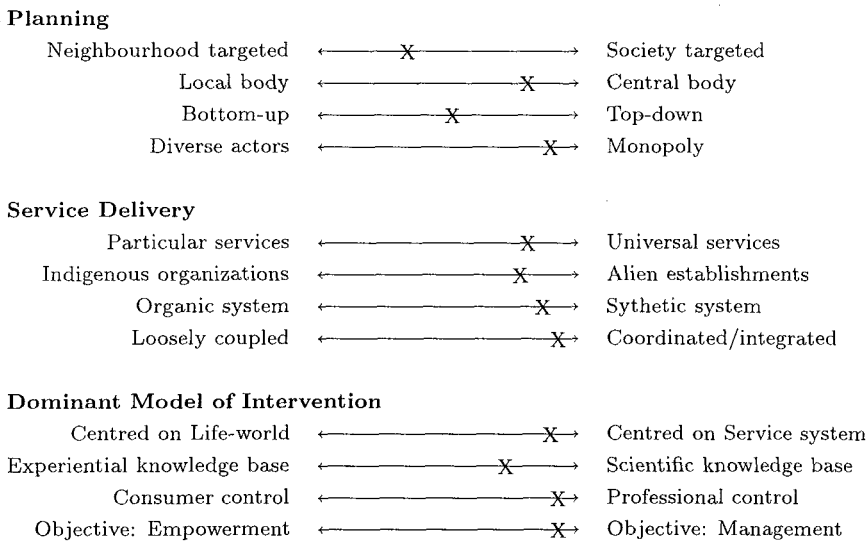
Smalltown is more distant from the Metropolis, covers a geographical area considerably more vast than either Suburbia or Cityfringe, and is less densely populated. Two small cities constitute two different hubs surrounded by numerous towns and villages and some rural areas. This makes for a sprawling district that lacks cohesion. While economically, it is principally an industrial, working class area, there are major differences between different localities within the district. It has a higher unemployment rate, lower educational level and older population than the two previous districts discussed.

The largest of the cities plays a central role in health and social services for the entire district since it houses the only hospital, the social service agency, as well as the district community health department. The hospital's small psychiatric unit is not a strong one, since established psychiatrists are typically unwilling to serve in this outlying area. All three of the public establishments have made up for this lack by becoming active promoters of mental health facilities outside of the hospital. Foster homes, a day hospital and a rehabilitation centre were all established prior to the adoption of the provincial mental health policy, on the basis of various hospital and social service budgets. The community health department has been a leader in evaluating needs and planning services in the mental health field. In many ways, this has been considered a model district in the Outskirts Region.

In contrast to Cityfringe, Smalltown's indigenous community associations have been more traditional than militant: they included church groups, service clubs and farm women's circles. During the 1980s, several CLSCs were active in organizing new voluntary organizations to support the disabled, for example, or families in difficulty, but these were not socially "radical" as were Cityfringe's movements for cooperative housing and daycare. Given its vast territory and especially the dual hubs, this district appears to lack the cohesive community identity and autonomous organization and activity that is more evident, though in different ways, in both of the other districts examined.

Given the same Regional Council as Cityfringe, local mental health committees established by the Council have generally been ineffective due to frequent changes in format and mandate, and lack of clarity regarding their relation to other local bodies and to the regional centre. But here in Smalltown, the strongest local leadership lies in the public institutions rather than with citizens' groups. Public network professionals have dominated the local planning bodies, or, when more convenient, have bypassed

Figure 6
An Institutional Community-Based Model



them altogether to obtain the funding to develop the resources they favour. Decisions regarding the district may be influenced by personal networks involving staff in local public health and social service establishments, and staff at the Regional Council; one prominent local leader in the mental health domain has been transferred to the Regional Council staff to coordinate mental health planning for the region.

A single alternative community organization in mental health has survived in this district for about a decade, and has held a seat on some local planning bodies. Despite attempts to expand its own services or sway the planning process, it has been uninfluential due to its isolation and opposition to the mainstream psychiatric practices that dominate the district. When, following the adoption of the provincial policy, the Regional Council chose to implement tri-partitism in the local mental health committee, the power balance within that committee was significantly altered, as community groups working in other domains — and even some CLSCs — came to the support of this single organization's alternative orientation. However, the committee itself has been uninfluential compared to the informal, parallel leadership of the public establishments. If in Cityfringe, militant leaders have established a near-monopoly over mental health resource development, in Smalltown, it is the public establishments that have done so.

All the resources recently established in this district since the adoption of Quebec's community-oriented mental health policy are indeed located

in the community — that is, outside the walls of the hospital. However, the largest sums of *new* funding are still controlled by the hospital and social service centre, thanks to aggressive planning and lobbying by their staff and directors. With these funds, they have set up such services as a network of short-term, emergency foster homes and a crisis team located in a CLSC, neither of which are independent. In fact, the CLSC crisis team is coordinated by hospital staff, despite the administrative autonomy of the CLSC.[8] The single independent community organization has received a minute amount of funding, enough for one bed to augment its housing facilities. As well, one self-help group has been established, but unlike the militant self-groups in Cityfringe, this one maintains close relations with the staff of the psychiatric department.

As Figure 6 suggests, the dominant intervention style in the system that has flourished in Smalltown corresponds to a professional model — bio-psycho-social, if not psychiatric — based on the concept of multidisciplinarity and complementarity. Despite the dynamism and relative autonomy of local planners, they are chiefly representatives of different professions and public institutions, not the local population. They have developed a service delivery system in the image of their professional network, one in which they and their institutions continue to play a leading role, and in which community organizations and self-help groups are clearly marginal and subordinate.

Discussion

The three examples of district-level mental health systems described here highlight some of the different processes and models that fall under the rubric of "community-based systems". This rubric is able to absorb a broad range of strategies for mental health care, from traditional services, to alternative resources and professionalized programs all provided *in* the community, though not always *by* the community. Are all to be considered community-based systems? Are some more "community" than others? Is a system that is highly community-oriented with respect to the three dimensions of planning, service delivery and practice model the most desirable?

This paper has not sought to answer these questions, but rather to raise them. One clear conclusion is that a system may lean towards the community in one sphere, while remaining firmly institutional in another — and that the local orientation is not necessarily linked to the regional one, despite the authority of the Regional Councils to prepare regional plans and implement them. The principal constant in the systems described would appear to be that they reflect the configuration and relative dominance of *local* actors, whether in highly decentralized regions such as the Metropolis, or more centralized regions such as the Outskirts.

For example, in Suburbia, local planning and the reinforcement of local community organizations does not necessarily prevent a growing professionalization and institutionalization of mental health intervention, due precisely to the community's own social composition and dynamics. The protective, even paternalistic culture of this district, in which middle class families are the predominant community actors, has a greater affinity with professional-institutional forms of intervention than with the philosophy of anti-psychiatry. In fact, ever stronger links with the hospital and social services are being forged, and community advocacy calls for more and better psychiatric services. Despite the predominance of voluntary organizations in this district, curiously, not a single self-help group for people with mental health problems has been funded — though there is a long-standing self-help group for their families which has been consolidated under the new provincial policy. In contrast, militant user self-help groups have been proliferating in some other areas of the province, for example, Cityfringe, supported by provincial funds.

While effective local planning has brought about important changes in Suburbia (even if their direction may seem paradoxical), the *lack* of decentralized planning has produced the opposite result in both Cityfringe and Smalltown. Here, the mental health systems have been totally captured by the traditional, dominant local leadership, which has maintained its position of strength through parallel channels of influence and effectively warded off important shifts in orientation. These two systems are more sensitive to political control than technocratic control. They lead to situations where people living in the communities are bound to monolithic forms of service delivery, and a single model of practice — alternative in one case, institutional in the other.

One hypothesis that might be drawn from these observations is that decentralized, local planning is better able to surmount traditional biases at the local level than is central planning. Rather than depending upon a single local actor or set of actors to informally represent the "interests" of the community as a whole, it permits the range of local actors to negotiate solutions. Locally-integrated planning makes room for the recognition of more than one indigenous way of doing things, and for evolving relations between the proponents of different models. But this does not imply that, as a result of local planning and leadership, service delivery and the dominant models of practice will necessarily be community-based. Local leadership itself may lean towards the development of an institutional network within the community, as may be the trend in Suburbia.

We might further hypothesize that local dynamics in the field of mental health will influence not only the organization of service delivery and the dominant practice model, but the local planning process as well. Without

centralized institutions and monopolistic, state-supported professional control over practice, it becomes virtually impossible to impose a particular system model across a large territory. The less formally decentralized the planning process — that is, the more a system can be held hostage to the most powerful local leaders — the more diverse systems will be in each district. On the other hand, the more formalized the delegation of planning power to local bodies, the better the chances of evolving a system that is not appropriated by a single set of local tendencies, since these may be checked by opposing local interests.

The examples presented here have shown that radically alternative systems can result from central planning, just as indigenous, "unprofessional" civic organizations can, under certain conditions of local planning, contribute to the development a highly structured and professionally-controlled service system. In other words, the various dimensions of "communityness" — planning, service delivery and practice — are not inevitably tied to each other, and institutional tendencies along one dimension can coexist, and in some cases even favour, community tendencies along another dimension.

One such permutation that has not been examined is the alternative, consumer-centred model of practice embedded in an institutionally-based service delivery system. Data is currently being gathered data in one district where this may indeed emerge to be the case. Here, a large psychiatric institution creates alternative, experimental resources using its own funds, but according to proposals and projects presented by local promoters and activists. The projects are implemented and operated by their originators, and appear to be more or less autonomous in their orientation and functioning, though vulnerable to somewhat arbitrary withdrawal of funds. The conditions under which this "partnership" model can be generated have yet to be distinguished.

Conclusion

From an analytic perspective, it becomes clear that the community discourse that is coming to constitute the dominant discursive strategy in the mental health arena today — much as "mental illness" did in a previous era — may be little more than that: a dominant *discourse.* This implies that most social groups or actors implicated in the field are likely to lay a claim to "ownership" of, or at least participation in, the "community" approach, or risk losing legitimacy. What a community-based system will actually consist of, however, seems to depend on prevailing social relations within the mental health domain in a particular time and place. Its dominant characteristics will depend upon the relations between the various social actors promoting it in a given context.

The strategies of central planning agencies, such as Quebec's Regional Councils, constitute only one element influencing an emergent mental health system, and may have a greater or lesser impact than local actors and their respective strategies. But if social groups favouring opposing strategies—everything from public-institutional control, to user-control, to technocratic control by a planning body—draw upon, and are judged by a single discourse, then the real differences in their positions are obscured. Suburbia's technocratic model, Cityfringe's alternative model and Smalltown's institutional model of planning, service delivery and practice can all lay claim to the community seal of approval.

Just because a mental health system appears to be able to develop in different directions along different dimensions at the same time, does not mean that each dimension is autonomous. On the contrary: an institutional model of service delivery has a determining effect on planning and practice models, just as technocratic planning influences the orientation of both service organization and practice. Likewise, the alternative philosophy of practice in Cityfringe has produced a single "family" of services and programs, mainly by bypassing the vaguely formalized planning process. This suggests that local outcomes of a policy are not so much a function of political, professional and administrative *resistance* to centrally-initiated change, but rather a question of the social actors present or absent on the local scene, *and the extent to which they are able to accomplish their local goals under the new rules and with the resources provided by the policy.* Quebec's mental health policy seems to be enabling different social actors in different localities, and appears to be used by them in ways they see fit.

Thus the discourse of "community" can be seen, on the one hand, to have blurred a range of strategies from the most alternative to the most institutional or, on the other hand, to have permitted a profusion of strategies corresponding to individual community dynamics, that is, to the *particular* social and cultural conditions under which those strategies emerge. For those policy-makers who would advance a specific organization of service delivery, or a specific model of intervention, the community-based mental health system may prove difficult to mould.

NOTES

1. The author would like to thank Ellen Corin, Cécile Rousseau, Céline Mercier, Suzanne King, Francine Desbiens and Marie-Claude Roberge for their valuable comments, as well as three anonymous reviewers.
2. This part of the paper draws on an ongoing multiple case study of the implementation of Quebec's mental health policy: "*Le développement des ressources communautires en santé mentale: la mise en oeuvre d'une politique*", funded by Health and Welfare Canada, National Health Research Development Program, Grant 6605-3342-64/4. The research is being con-

ducted by the author with the collaboration of Céline Mercier, McGill University.

3. The medical discourse has not lost its legitimacy, however, and is still the preferred discursive strategy in medical circles where it justifies professional practices, as well as amongst many families of people with mental health problems, for whom it provides explanations, partial solutions, and absolution through the familiar practices of medical diagnosis and treatment.
4. Thus, our argument is *not* that the development of a community-oriented "ethic" was a driving force behind deinstitutionalization policies, but only that it provided these policies with a discourse by which they could be promoted.
5. The term "success" is itself impossible to define since it inevitably refers to particular objectives and criteria which are rarely made explicit in the literature. Resorting to a residual definition of a community-based system, I take "success" to mean an effective reorientation away from a more traditional system in which most care and services were provided in an institutional setting.
6. The Quebec mental health policy does *not* endorse an expansion of private-for-profit services, which are currently rare with the exception of psychiatrists who have opted out of medicare.
7. The Association for Psychiatric Alternatives is a "civil society" association, since it was born of the intitiative of the local leadership and is under no form of government regulation or control. In contrast, the advisory committee is state-mandated: it is an arm of the Regional Council which seeks to involve citizens in its work, and can be (indeed was) modified or eliminated by fiat.
8. The apparent justification for hospital control over a CLSC program in this case was the lack of psychiatric expertise amongst the CLSC staff.

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