The Incomplete Revolution: the development of community work in Quebec CLSCs

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ABSTRACT This article surveys the history of community development in the local health and social service centres (commonly referred to as CLSCs) in the Province of Quebec. These developments are tied to three major steps in the evolution of policy as set out in a series of published reports. The development of the philosophy and mandate of the CLSCs is discussed and placed within the larger historical context of the 1980s as fiscal conservatism impacted on their operation and especially as it affected their community development role. The impact of these developments on the practice of community intervention work is presented in a case study, drawn from the author's experience as a participant observer in one urban CLSC. Linkages are made to policy developments as set out in the reports. The article concludes with an examination of current directions in community development policy and practice and makes some recommendations to strengthen these developments.

Historical and Cultural Background

The Province of Quebec has a unique system of local community-based health and social service centres created some twenty-five years ago to serve the first line health and social service needs of the population. (The Canadian constitution places health and social services, as well as education, under provincial jurisdiction). Beginning in the 1960s Quebec governments have increasingly asserted these constitutional powers, as part of viewing the Province as a distinct society within the federal system. They have also maintained that the province is a 'nation' having a distinct culture based on the French language and on 350 years of continuous history.

The creation of the CLSCs by the government of the day was part of the modernization of Quebec society that took place in the 1960s referred to as Quebec's 'quiet revolution'. Included in this transformation was a large-scale redevelopment and expansion of the social and education systems at all levels. Before these changes took place, education, health and social services for the French catholic population were funded by the government but under the auspices of the Roman Catholic church. This process of modernization also involved the development of state-owned corporations

in many primary production areas as well as in the production of hydro-electricity and in financial services. The overall goal of this process was the development of a modern state having the means within it to educate a contemporary work force and to care for the needs of its citizens. To accomplish this, the political leaders patterned the changes to the social service and health care systems on similar models found in the Scandinavian countries and in Great Britain. These models are in use in other Canadian provinces and at the federal level. They rest upon the assumption that the role of the state in the development and delivery of health and social services is to provide a social umbrella of protection for the well-being of its citizens. They also assume those social democratic principles and policies that have come under attack in more recent years as monetarist policies found favour with governments in power.

The government established CLSCs so that health and social services would be responsive to local needs and problems. These bodies also have a specific community development function and employ community intervention practitioners. CLSCs have been most successful in responding locally, when these are relatively universal needs such as the provision of home care for the elderly. They have also provided walk-in-clinic medical access to people who historically had no family physician.

Philosophy and Mandate

The government established the first group of CLSCs in 1970 during a time of broad support in Canada for the war on social problems. This took place before the energy crisis caused government leaders to rethink and to drastically change their social and economic priorities. The idea of participative democracy was widespread and popular and formed the explicit philosophy of the CLSCs. This included such notions as 'participation, consultation, democratization and (central) planning'. These ideas were part of the vocation of the CLSCs from the beginning (Poupart *et al.*, 1986).

Each CLSC embraced a population of about 40,000 to 45,000 residents to ensure close contact with the needs and problems of its local residents By 1980 the entire population of the Province was served by CLSCs. The governance of CLSCs was by boards of directors which included local residents as elected members. CLSC workers elected members to represent them on the board. The state philosophy of the CLSCs was to function in an 'associated partnership' with the population. It was also the stated intention that they be run along the lines of participative management involving their employees. Health and social work professionals were to be accountable to citizens, management and other workers (Poupart *et al.*, 1986).

The mandate given to the CLSCs to provide first line health and social services emphasized disease prevention and public health measures. Existing parapublic agencies (hospitals, child care agencies, etc.) remained

in place but were incorporated into the larger public health and social care system that now included the CLSCs. The services of physicians and dentists continued in place while a significant number of physicians came to be directly employed in the CLSCs. The architects of this system, of which the CLSCs were a major feature, social life from a technocratic perspective with emphasis on planning, programming, rationality, modernization and adaptation as the principal themes. In establishing the needs of the population, methodologies of the professionals took priority. The use of survey research with its philosophical basis in the scientific method became standard as did the use of the 'interactive method' of consultation with social agents and organizations. These approaches were summed up in a 1986 analysis of the CLSCs as '*intervenir, c'est servir; servir, c'est intervenir*' (to intervene is to serve; to serve is to intervene) (Pourpart *et al.*, 1986).

In describing the particular definitions given to the community work interventions undertaken in CLSCs, Poupart *et al.* identified two approaches: 1) a pedagogical approach that focused on attitude change among the population; and 2) an instrumental approach through which interveners work with community leaders and community organizations. The study concluded that the best way of describing CLSCs is as vast enterprises of education.

Developments in the Mid-1980s

With the passage of time and the election of a fiscally conservative (though no less technocratic) government, the CLSC system came under increasing financial and political pressure. This has come about as government officials sought to manage the provincial budget by sharply curtailing expenditures in education, social services and health care that together make up more than half of the Provincial budget. Ironically, when the published figures are examined, the total cost of the CLSCs in the budget of the Ministry of Health and Social Services was $344,700,000 or 5.5% in 1986–87, an amount that is slightly lower than that of the previous fiscal year. The Minister of the Department of Health and Social Services commissioned a study (popularly called the Brunet report) which examined the current state of the CLSCs and made some important recommendations for their future. The changes proposed are particularly significant with respect to the community orientation of the CLSCs and to the work done by their community workers.

The report began by noting that there are now some 150 CLSCs in Quebec found in every region except in the sparsely inhabited far north of the Province. The report noted that since the first CLSCs were established there have been important social developments. These developments include the aging of the population, an increase in drug abuse and in the incidence of sexually-transmitted diseases which has resulted in an increase in admissions to physical and mental health hospitals. The report also observes that differences remain in the state of health of different ethnic and economic

groups and between different classes of workers. In its discussion, the report presents a definition of 'state of health' as the capacity of the individual to adapt to his (*sic*) environment and to function there in an adequate manner. The report emphasizes that the CLSCs should continue to concern themselves about the social environment, the workplace and the economic environment in considering the health needs of the population. It emphasizes that CLSCs should continue to be the first point of contact of the population for health and social services (Brunet *et al.*, 1987).

What the Brunet report does not say is that most middle class citizens continue to use their family physician as the first point of contact with the health system. Under the Quebec system, mandated by the rules of the Canadian federal health legislation, the vast majority of physicians continue to function as independent medical entrepreneurs who bill the provincial government for the services they provide.

The report lists a number of difficulties facing the CLSCs in carrying out their mandate: 1) there is resistance from existing public sector health and social service organizations to giving the CLSCs the resources they need; 2) there has been a lack of clear policy directions from the Ministry of Health and Social Affairs since 1977: 3) there is evidence that the boards and the management of CLSCs have difficulty in understanding their mission and their appropriate spheres of practice; 4) there are problems due to what the report calls a measure of political militancy on the part of staff unions (union activists have seen to it that staff members sympathetic to their views get elected to CLSC boards).

On the basis of these observations the Brunet report made a number of recommendations designed to update the policy and practices of the CLSCs of the Province. It recommended that: 1) a common level of services be established among all CLSCs; 2) emphasis be laid on early detection and first-line treatment of medical and psychological problems with appropriate referral; 3) the home care program be expanded; 4) four program areas be established for 'groups at risk' consisting of infants and families, youth in difficulty, adult mental health problems and one other group at risk, selected by the CLSC, that has importance in the area it serves; 5) limit the activities of the community action component to avoid duplication with the work of other government services (Brunet *et al.*, 1987).

It does not take much analysis to see that the medical model view of social problems has largely won the ideological day. It is not irrelevant that the chairman of the committee making the report and whose name gave it its unofficial title, is a physician himself. The report defines problems narrowly with the result that the linkages between problems are obscured. The Brunet report seemed to miss the complexity of human problems that CLSCs face and its recommendations would force them to engage in piece-meal problem solving. The founding philosophy of the CLSCs is that social and health problems are seen in their larger social context. The Brunet report ignored this.

At present, CLSC boards are top-heavy with government bureaucrats (*Rapport annuel*, 1986). They manage to keep the operation of their respective CLSCs reasonably honest with respect to fiscal management. The potential of the boards to become a conduit to the community and a sounding board for the community in matters of health and social policy, has been largely unexplored. The boards consist of three groups: service agency bureaucrats; CLSC users; and union-oriented CLSC staff. The recommendations of the Brunet report do nothing to encourage the improvement of community input at the Board level. The report fails to recognize the roots that CLSCs have put down in their communities, and makes no recommendations that would strengthen this aspect of their mandate.

Case Study of a Community Work Team in One Urban CLSC

Background

While on sabbatical leave in 1986–87 I spent seven months as a privileged visitor with the community workers of an inner-city CLSC in Montreal. This permitted me to observe at first-hand the workings of the organization and in particular the activities of community workers. I was also able to observe the interaction between the CLSC staff and the community it serves.

The CLSC covers an area in the city of Montreal of considerable historical significance. The population has grown due to successive waves of immigrants since the turn of the century. Jews, Poles, Ukrainians and Central European immigrants arrived before and after the first World War. Since the end of World War II Italians, Greeks and Portuguese have arrived to inhabit the same cheap housing, to establish the incredible variety of small businesses to be found here and to set up the churches, synagogues and other community organizations that are a vital part of ethnic adaptation to a new and unfamiliar world. Today, with the arrival of immigrants from South America and the far east, this CLSC serves the most heterogeneous population in the Montreal urban area. The district has a mixture of commercial and residential use. People live in high density row housing, most of it dating back to the first decade of this century. There is some light manufacturing in the area, for this is the centre of the clothing industry in Montreal, which has access to a continuing supply of cheap, immigrant labour.

This CLSC had been in existence for about fifteen years. The Director-General had been in office for about five years. Like other CLSCs it has a board of directors that represents public agencies and community interests. Of the fourteen board members, one was the Director-General, four were clients of the agency, three were drawn from community groups and three were elected by the staff of the agency. The Board also included an official with the senior citizen housing agency, a representative from the Social Service Council of which the CLSC is a part, and a representative of the

Hospital Centres Council. The Board represents various interest groups who have a concern about its operation. There are three effective groupings: the Director-General and the representatives of official agencies are one group; the users and community group people represent another block of people; and the CLSC workers form a third block. Each of these groups tend to have a distinct point of view, one that is somewhat at odds with the others. The first group is the most numerous and the most powerful. The views of its members tend to define the needs of the population that are addressed.

There were 82 people employed at the CLSC in 1986, 63 designated as program personnel and 19 as administrative. The program personnel included 19 nurses, 10 physicians, 16 home care workers, 3 social workers, 7 social assistance technicians, 5 community workers, 2 dental hygienists and 1 nutritionist. The rest of the program staff are in various support roles. The administrative personnel include six people in managerial positions and the rest are in support roles (*Rapport annuel*, 1986). It should be noted that only five employees are community workers, representing just 6% of the staff total. In contrast to this, the home care program has 16 workers (19%) and health-related programs employ 31 people (37%). The large numbers of nurses and physicians represented on the staff ensures that the medical perspective will be the most prominent point of view in considering the social and health problems addressed by the agency. The strong emphasis on the home care program has the effect of defining community people as dependent clients to be cared for rather than independent adults to be enabled to care for themselves. These realities are reinforced by the distribution of the program budget. Home care services receives 24% of the budget, social services 11%, maternal and child care 8%, current health services 4%, school health 5%, seniors residential care 4% and the preventive dental program 3%. Community action received 6% of the budget, most of it for salaries. It should be noted that except for community action, the rest of the program budget is allocated to service delivery activities.

A 1985 study of downtown Montreal areas served by CLSCs indicated that poverty is a major problem in the area covered by this CLSC. This area had the highest incidence of hospital admissions for mental problems in central Montreal. Unemployment, drug addiction and delinquency are severe and visible social problems in the area. Gentrification has added to these problems as middle class people move in to buy and renovate the row housing common to the area. Thus the availability of cheap rental housing, on which the working poor and the unemployed rely, is disappearing.

These obvious social problems figured only peripherally in the program thrust of the CLSC. It confined itself to providing medical care to a walk-in clientele and home care to the elderly and hospital discharges. These are sorely-needed services but the CLSC has barely begun to address the major social problems of poverty, homelessness, addiction and mental health problems. Only the community workers were attempting to deal with these

problems. One was working on a housing proposal for poor singles. Another worked on developing a meals on wheels proposal. Both these efforts were addressed to the serious poverty and the social isolation so evident in the community.

An Experiment in Team Building

A senior staff member had recently organized the community workers as a community intervention team. Subsequently this senior staff person left the agency. Since community workers tend to work alone, this presented me with an opportunity to observe the development of a community work team from its inception. The team members were supervised by a senior staff person who already was responsible for overseeing several other program areas including the home care service which was the largest single program in the CLSC. Team members informed me that the Director-General was doubtful about grouping the community workers together as a team but allowed it as an experiment.

The community has many different groups and organizations. Most of them are quite small, and the CLSC community workers have been instrumental in bringing workers from them together in '*tables de concentration*'. This enabled them to keep a finger on the pulse of the community and to engage with these non-CLSC workers in collaborative action on community issues. Each community worker sat on one or more of these groupings.

I met with the senior staff person who supervised the team members' work. He spoke of the difficulty of giving them adequate supervision because of the press of other responsibilities. He had no community work experience and seemed not to understand their needs: he never attended their meetings.

After seven months the Director-General announced that the team was to be discontinued, and its members dispersed to various program areas where they would continue their community work. He presented this decision as ending a temporary measure now that the new supervisor had become familiar with his portfolio. This was a set up for failure, both by the failures of the management of the CLSC as well as because of the limitations of the team. As will be seen below, it tended to confirm the apparent wisdom of the recommendations of the Brunet Report, which was released just as the team was disbanded.

Observations

The break-up of the community development team was presented as a matter of tidying up an organizational anomaly and justified by the recommendations of the Brunet report. Senior management had doubts about the usefulness of a community worker team from the beginning.

Consequently, the team received no coherent mandate, nor did the management of the CLSC give the team adequate supervision. No team leader was appointed and they did not provide a framework of goals and objectives to focus the team's work. At the same time the workers failed to perceive the need to act together, and did not develop and use the leadership resources within their group. Taken together, this made it easy to dismiss the team as an experiment that didn't work and break it up. It was my observation that the team was unable to 'get its act together' and to build from its strengths. Among these strengths were the strong community connections nurtured by the five community workers. The team members never faced and identified their own internal problems. They failed to develop mechanisms to provide the mutual support they needed from the other members of the team. Because of this they were unable to confront and solve their need for leadership and for collaborative planning and work. Had they been able to do these things, they might have made their position as a team of workers in the agency more powerful and made it much more difficult for the management to bring the experiment to a close.

In spite of this lack of collaboration in the team, it was clear from the experience of one of the workers that collaborative work was possible in the agency. The team was asked to develop a meals-on-wheels program for agency clients. They responded by objecting that this was a too-simple solution to a much more complex problem. However, one of the workers then joined forces with other professionals in the agency to study the problem. The study resulted in a report with a set of recommendations that recognized the complexity of the issue and made several practical proposals for action. The worker involved told me that the report was well-received and that he had received a considerable lift from working with other professional colleagues. It should be noted that his collaborators were not members of the community development team, but professional colleagues working in other program areas of the CLSC. This raises the question of the appropriateness of the kind of collaboration appropriate for community workers. His experience clearly indicated that the participation of community workers in multi-disciplinary work teams is entirely feasible.

Why was the community development team unable to act together in their own interests to preserve the team? It is easy enough to see what they did not do, but less easy to see why they could not act in their own declared self-interest. Perhaps the individualism and isolation reported below is one reason for this failure. It appeared to me that they had no clear notion of the importance of working together and few skills in doing so. None had any training in group skills and members of the team consistently ignored issues affecting their relationships in favor of attending to the tasks that faced them. There was evidence of feelings of anger and being left out of decisions taken within the CLSC but these concerns were never addressed collectively and the team took no action. Without a strong grasp of group work skills on the part of at least some of the workers, it was not possible to build and

maintain a strong team of community workers. It was clear that they were not getting from each other what they needed, which was collegiality and support, and that they could not collaborate effectively in working together.

With this kind of confusion in the community development efforts of CLSCs, it is not surprising that the Brunet Report recommended the ending of the community action role of the CLSCs. The recommendations of the report would, if implemented, result in sharply reducing the responsiveness of CLSCs to their communities that had been so important a feature of their creation. As I left the CLSC it appeared that the survival of community development was in serious jeopardy in this urban CLSC.

The Current Scene

The Federation Report

Five years later, in spite of the recommendations of the Brunet report, CLSCs continue to employ community workers. A recent document prepared by the Fédération des CLSC, reports on a systematic assessment of the community work program of the CLSCs (*Practiques d'action communautaire en CLSC*, 1993).

The Fédération report begins, as did the Brunet report, by stating that the fundamental mission of CLSCs is to provide preventive health services and to enhance the social well-being of the population. Unlike the Brunet report, this study gave particular attention to the work of community interveners in the CLSCs. Perhaps it would better represent this document to say that its central message emphasizes the community context in which social problems occur and to underline the need for a coordinated community-based response to them. The report presents the basic health and social issues as aspects of poverty affecting the various clienteles of the CLSC such as unemployed youth, single parent families in difficulty, older workers, older women, aboriginals and the handicapped. The report argues forcefully for linking community intervention work to all existing programs of the CLSC. The report uses case study examples to make this argument, showing how this collaborative approach has been used in a number of urban and rural CLSCs. It argues that community action is the necessary route to intervening successfully in social problems. It proposes that efforts to tackle these problems depend on developing a community consensus, on networking with various organizations and agencies, and on mobilizing citizen action. These are the interventions that community workers are trained to carry out and which represent their special, professional role within the CLSC. Unlike the Brunet report, the authors of the Fédération study included both community workers and academics with knowledge and expertise in social intervention work. The Fédération study indicated that community action is alive and well in the CLSCs. It signalled an understanding of the social intervention role of the CLSCs that is more comprehensive and better grounded in social reality.

CLSC Workers Speak their Minds

In spite of this encouraging development, community workers continue to suffer a measure of marginalization in their work. I recently co-led a workshop on conflict resolution for CLSC community workers. The workshop evaluations indicated that participants found the most valuable aspect of the workshop was in bringing them in touch with colleagues working in other CLSCs. Participants also spoke of isolation in their work as a continuing problem. They spoke of the importance of autonomy and they valued the opportunity given them to exercise a wide margin of manoeuverability in working with community organizations. The workshop participants also emphasized that senior administrators and other colleagues failed to understand the work they did. A consequence of this was that the workers often found themselves in conflict over appropriate roles and responsibilities with their supervisors. It appears that a close attachment to the community and its organizations often results in detachment from the CLSC organizational structure. The freedom of action that workers experience can also engender suspicion among colleagues who are not so free. One of the problem situations presented in the workshop was a case study that described how a community worker had been shunted aside in implementing a program. He had invested many months of work on this only to discover on his return from vacation, that a senior administrator had implemented the program on which he had worked so long. This situation spoke so powerfully to all the workers present that it clearly represented a situation they had experienced all too frequently. In most of the conflict situations presented by the workers it was clear that they experienced a persistent problem with client groups in defining exactly what was and what was not an appropriate role for a community worker.

It appears that role definition and role misunderstandings both with workers' constituencies and with colleagues and supervisors continue to present problems in their work. The workshop participants reported being required to fill many different roles, both by community participants and their organizations as well as by CLSC supervisors.

Conclusion

The philosophy and practice of community development continue to evolve in Quebec CLSCs. After two decades of growing pains, there appears to be a resolution of the understanding of the community focus that was so important a part of their initial mission. Instead of seeing community development as a separate and special program of the CLSC, a philosophy of community development as integrated into the organization of CLSCs is emerging. This emphasis would see community development not as a separate program area but as inhabiting a position of central importance in the developmental aspect of all the programs of the CLSC. If this continues,

community development will become the organizing approach used to grapple with emerging health and social problems in any program area. Under these circumstances, community workers will become recognized as specialist members of multi-disciplinary problem-solving teams. This is the main thrust of the recent Fédération report. It urges community workers to become more professional, more articulate, and more assertive of their proper role within the mission of the CLSCs.

Left unsolved are the problems arising from the isolation that workers experience in their day-to-day work. Some form of collaboration between workers within particular CLSCs such as was attempted in the case described above could still be helpful. An alternative would be to foster inter-agency relations that encourage sharing and joint problem-solving. A loose association of community workers already exists and although it is not part of the structure of the individual CLSCs or of the Fédération, it goes some way towards meeting this need.

Community workers in multi-disciplinary social agencies in other parts of the world face similar problems. In Israel there has been an attempt to provide supervision for community workers either within particular agencies where numbers warrant it or by grouping together workers from several agencies for this purpose. The results reported left a residue of isolation problems. The inter-agency model placed supervisors too far from the work of the individual community workers to be really helpful. On the other hand the agency-based model tended to be ineffective if the supervisor was unfamiliar with community work (Gidron & Glaser, 1979). Nonetheless these efforts offer some promise for the Quebec situation and focus attention on the problem of worker isolation.

To enhance community development in Quebec CLSCs a number of conclusions can be made. The boards need to have community membership strengthened in order to ground policy discussions in the lived reality of populations in need. A shift in money, staff but most especially in program emphasis is required in order to focus more attention on social problem identification and on development strategies. The Fédération of CLSCs should adopt the recommendations of its own report and provide a general development mandate for individual CLSCs to work within. CLSCs could then take these recommendations and develop specific development mandates for their staff. Community workers should be included as members of multi-disciplinary work teams which receive proper work supervision. Community workers should be provided with training in group work and team building and this would add significantly to their arsenal of special skills. Community workers remain isolated in their work. In part this is a consequence of the kind of work they do. Isolation can be overcome by regular but not highly structured opportunities for supervision and sharing among workers, led by experienced community workers. This should not be understood as work supervision. The message from the case study reported above and from the Fédération report is that multi-disciplinary work teams

are an effective venue to use community worker skills, and this is where work should be supervised.

Community workers have a valuable and indeed unique contribution to make to further the purpose for which CLSCs were established. They can best make this contribution when they are placed in work situations where their skills are used and therefore come to be recognized and appreciated. Their community contacts, their ability to work with diverse populations, their skills in carrying out community investigations and their understanding of the interactive and developmental process that can be used to empower community members in the solution of community problems are best realized in collaborative work with other professionals with different skills. They also need the support and understanding of their unique and often difficult role that can best come from others who do this work.

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