Deinstitutionalization and Vocational Rehabilitation for Mental Health Consumers in Nova Scotia since the 1950s

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JOHN RUTHERFORD*

In this paper we explore the broader policy determinants of the de-hospitalization of mental patients in Nova Scotia between the 1950s and 1980s and trace the background to the development of occupational rehabilitation programs in the community. For employment programs, the government chose to rely on non-profit NGOs as the suppliers of services. As a case study of such an organization, we examine the evolution of LakeCity Employment Services Association as a resource for people living with mental disabilities.

Dans le présent article, nous explorons les grands paramètres de la déshospitalisation des malades mentaux en Nouvelle-Écosse entre les années 1950 et 1980, mouvement dont le cours remonte à l’élaboration de programmes de réadaptation professionnelle dans la collectivité. Dans le cas des programmes d’emploi, le gouvernement a choisi de confier la prestation de tels services à des ONG à but non lucratif. Nous étudions le cas de la LakeCity Employment Services Association, qui s’est transformée en ressource pour les personnes vivant avec des problèmes de santé mentale.

IN THESE early years of the 21st century when few institutions dating from the age of the asylum remain, scholars are turning a critical eye to the influences that shaped deinstitutionalization and the services that replaced conventional mental hospital care. Our research focuses mainly on community supports in the form of designated housing, employment,

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and social programs for the “post-mentally ill,” a misleading term used in the 1970s and 1980s to describe somewhat paradoxically people diagnosed with chronic mental illness who had recently been discharged from hospital.\(^1\) An understanding of how such programming came about helps explain the evolving approaches to de-hospitalization, rehabilitation, and recovery. The existing literature on this subject explores the various vocational models and identifies the inter-professional tensions around rehabilitation, as well as the differences in perspective between practitioners and clients. Since such publications are designed primarily for mental health service providers, they include little analysis of change over time.\(^2\)

In this paper we explore the broader policy determinants of deinstitutionalization in Nova Scotia between the 1950s and 1980s, trace the background to the development of occupational rehabilitation programs in the community, and, as a case study, examine the evolution of LakeCity Employment Services Association as a resource for people living with mental disabilities. While observers of community programs are unlikely to view them as analogous to institutionally based services, they are nonetheless part of the same support system. The features of the system, like the disabilities themselves, represent a continuum or spectrum. Over the past half century that continuum has expanded to include a range of new institutional approaches. The institution of bricks and mortar still has a presence at one extreme of the spectrum; at the other, virtual institutional programs like LakeCity constitute what we have named the open asylum.

**Government mental health policy**

The background to the transition from hospital to community can be found in the 1950s and 1960s. In that period, mental health services in Nova Scotia, and indeed throughout most of North America, were influenced by such developments as the introduction of psychotropic drugs, the psychiatric profession’s preference for general hospital care over asylum care, and the establishment of multidisciplinary community clinics as centres for both medical consultations and non-clinical services.\(^3\) In addition, local investigations into patient abuse and staff inadequacies

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1 Townsend to Miller, 8 February 1982, Nova Scotia Archives (NSA), RG 25, vol. 620, no. 3
in the province’s three largest municipal mental hospitals mirrored the international unease over institutional care. During this period the three institutional options were the provincially funded Nova Scotia Hospital, one of the municipally funded mental hospitals, or, where available, the psychiatric ward of a general hospital funded by 1959 under the federal hospital insurance scheme. From a medical perspective, the system could be described as three-tiered, each tier depending on the severity, duration and prognosis of the illness. This meant that a patient admitted through emergency or private-practice referral to a general hospital psychiatric ward might, after a few days, be transferred for specialty treatment to the provincial hospital. Failure to respond to treatment after several months in that setting might result in admission to the municipal mental hospital in his/her place of “settlement” as a chronic (i.e. “incurable”) case. Reform of the province’s exclusively public mental health institutional system, including the reduction of its hospitals both in number and in the size of patient population, was influenced by government decisions in the 1950s, 60s and 70s which were driven as much by financial considerations as therapeutic efficacy.

The first reform occurred in 1958 when provincial mental health services director Clyde Marshall devised province-wide standards and encouraged the municipalities to adopt them for their mental hospitals as a prerequisite to qualify for the first provincial funding in their history which would cover one-third of their operating costs. In 1955, when the Mental Health Services division of the Department of Public Health took over the inspection of mental institutions, there were seventeen municipal mental hospitals, each housing anywhere from a handful to several hundred patients. Nine hospitals survived the introduction of the first round of Marshall’s new standards of care. All of these were then known as “county hospitals” except the one in Halifax city, which was usually referred to as the Halifax Mental Hospital. The eight others were either abandoned or became welfare homes under the aegis of the Department of Public Welfare.

The second decision of the provincial government was reached in 1965. This was to take over entirely the financial responsibility for patients in municipal mental hospitals, thereby ending in Nova Scotia on 1st...
January 1966 the effects of the deliberate omission of this category of institution from the federal government’s 1957 hospital insurance scheme, implemented by the province in 1959. As a result of this initiative, by 1967 only four municipal mental hospitals remained: Halifax County Hospital in the Cole Harbour suburb of Dartmouth, Halifax Mental Hospital in the capital which in 1971 was replaced by Abbie J. Lane Memorial Hospital (referred to as the Abbie Lane), Kings County Hospital in Waterville, and Cape Breton County Hospital (usually shortened to Cape Breton Hospital) in Sydney River. The rejected hospitals became homes for the disabled under Welfare (hereafter used to identify the provincial social service authorities), intended mainly for adults considered to be mentally retarded.

In order to afford the reform of mental hospital care without the federal funds available to general hospitals, the Hospital Insurance Commission proceeded to promote the classification of patients according to a set of criteria designed to separate the minority—treatable patients who would stay in hospital—from those in the majority—patients deemed incurable or non-responsive, whose main problems were old age, physical decline, mental retardation, burn out or hospital dependency as a result of decades of institutional life. The patients in this second category, identified as not benefiting from “active psychiatric treatment”, were to be dehospitalized. At the same time, a fortuitous new federal anti-poverty plan enshrined in the Canada Assistance Act, the Canadian Assistance Plan or CAP, provided the means to cost-share the care of ex-mental hospital patients, rejected by Health (hereafter used to identify the provincial health authorities), in two new sets of institutions labelled homes for the aged and homes for the disabled. CAP was also one of the influential factors in situating the oversight of vocational rehabilitation within Welfare’s orbit. In this round of ‘mass’ de-hospitalization and transinstitutionalization approximately 1000 people, including 127 children described as severely retarded, were discharged as mental hospital patients. For the children four provincially owned homes were established, one each in Dartmouth, Digby, Pictou, and Sydney.

The third decision, which was to eliminate “The traditional concept in Nova Scotia of two types of mental hospitals (long term and short term)”, was taken in 1975. This approach meant a transition from five long-term care institutions and one short-term care institution to three

Table 1: Approximate Populations of Nova Scotia’s Mental Hospitals and Re-Institutional Facilities for Selected Years

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<td>604</td>
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1 Adult Residential Centres - Retained by Welfare/Social Services as homes for the mentally disabled.
2 Regional Rehabilitation Centres - Administered by Social Services.
3 Closed in 1971.
4 Psychiatric bed capacity in Camp Hill Hospital during closure of the Abbie Lane.
5 Closed by Health in 1961.
6 Psychiatric bed capacity.
7 Asterisks indicate no individual institutional data available, total is for Cape Breton, Halifax County, and Kings.
hospitals for full-scale care—the Nova Scotia, Abbie Lane, and Cape Breton Hospitals—and the transfer of Halifax County Hospital and Kings County Hospital to Social Services. This wave of targeted classification and de-hospitalization also resulted in the formation of regional rehabilitation centres in Halifax, Kings and Cape Breton for a range of residents believed to suffer from such problems as permanent brain damage, dual mental afflictions, and behavioural disorders. The de-hospitalization and transfer to rehabilitation centres was facilitated by a precedent that occurred in New Brunswick where the federal government agreed to cost-share under CAP the care of post-mentally ill patients, including those requiring long-term rehabilitation, in designated social service sections of that province’s two mental hospitals. These units were to be called “homes for special care”. In Nova Scotia this round of deinstitutionalization, through which another 800 patients were de-hospitalized, did not go smoothly given the severe extent of the chronicity of the illnesses of most of the patients and the pressures on the remaining institutions in the late 1970s and early 1980s.

A much more recent round of deinstitutionalization, a fourth one as it were, began in 1991 under the Department of Community Services and saw the closure of the children’s training centres in the 1990s (the four more recently established ones and the original one in Truro, opened in 1930) and, in 2002, the Halifax County Regional Rehabilitation Centre. This series of closures reminds us that the department known over the years as Public Welfare (until 1973), Social Services (until 1987), and now Community Services was a key player in deinstitutionalization and transinstitutionalization from the very beginning of the phenomenon. Indeed in the 1960s and 1970s, the mental health classification process

10 Townsend to Hare, 21 January 1976, RG 25, vol. 618, no. 1: Future Role of Mainland Mental Hospitals. In the event Kings retained some space for “Health” cases. The Halifax County Hospital, which was not designated as a psychiatric facility, looked to the Nova Scotia Hospital for mental health services. Cape Breton Hospital’s Braemore annex was also transferred to Social Services.


12 These included: a) the closure of the Halifax County Hospital and, to a major extent, the Kings County Hospital as mental hospitals and their re-designation as rehabilitation centres; b) the activation of the Abbie Lane Hospital as an equivalent treatment centre to the Nova Scotia Hospital, each with its own catchment area, except for several categories of patients chosen to remain exclusively at the Nova Scotia Hospital including children, for whom services were begun in the early 1970s, alcoholics, forensic cases, TB sufferers, and later psycho-geriatrics; c) the closure in 1981 of the Abbie Lane to facilitate its integration into a proposed new medical complex at Camp Hill, a long drawn out process, during which the Abbie Lane became a unit of Camp Hill Hospital, both the ‘municipal’ Abbie Lane and the ‘veterans’ Camp Hill having been purchased by the province; d) a re-enforced multi-purpose mental health care role for the Cape Breton Hospital and the Braemore facilities on its grounds as the service provider for Cape Breton Island; e) continuing discussion of the need for a “Facility X” for severely retarded adults until opening of the Mount Hope Centre in 1992.
not only decided who should remain in hospital under Health but also who should become the primary responsibility of Welfare, for it was recognized that few of those who left the health institutions could escape reinstitutionalization or public dependency of some sort in the community. As the committee on the future role of the mainland mental hospitals reported in February 1976 with respect to the transfer of patients to the jurisdiction of the Department of Social Services: “It is anticipated that the percentage of patients who are not indigent at present and who will subsequently be responsible for part of the cost of their care is very small . . . [only] 5% at the most . . .”13 In other words, it was recognized that chronic mental illness was usually synonymous with poverty.

Although most of the hospitals that were closed as mental health facilities in the 1950s, 1960s and 1970s became institutions under Welfare, this type of rearrangement does not imply that classification and reassignment for continuing care was ever a straight-forward, non-controversial, expeditious process. The head of Welfare’s classification committee for many years was a real stickler for the rule book and if he did not like the look of a patient, that patient was not decertified to the care of his department. Apparently the mental hospitals tried hard to train their patients to perform satisfactorily in front of the classification committee in order to dispel the fears of welfare agents that they would exhibit unseemly, destructive or violent behaviour in the community.14 Not surprisingly, the institutions under Welfare that replaced many of the hospitals and took in former mental patients were soon being criticized in their new role. While some of the criticism came from the leading mental health advocacy organizations, provincial bureaucrats could be equally scathing in their opinions. Social Services deputy minister Fred MacKinnon thought his department’s use of the privately owned Scotia Nursing Home in Beaverbank, really the only home for disabled persons residing in the Halifax city and county area, endorsed “a hodge-podge nursing home caring for everyone from birth to death . . . The kind of patient mix-up that we have tolerated up to now, wherein the retarded are being cared for in a nursing home complex, which, in reality means we have a duplication of the 19th century poor house in modern terms, [is a practice which] must be stopped”.15 But even the unsatisfactory facilities did not have room for all the patients approved for discharge, including some whose ability to function was severely compromised. For example, in 1975, one of the men waiting in the Abbie Lane for a bed in a home for

14 Interview with Everett Smith, 2004.
the disabled had been housed since 1929 either at the Nova Scotia Hospital or the Halifax Mental Hospital/Abbie Lane.16

Alternatives in the community to hospital beds and private “nursing” homes and boarding homes were sadly lacking. Amongst government agencies only the cities, which at that time still had social planning in their municipal mandates, gradually adopted foster home programs and opened group homes and later supervised apartments.17 The boarding homes run by the private sector were often devoid of the most basic services including the social activities that had become customary in hospitals by the time of the large-scale discharge of patients. The failure of the medical authorities to ensure that appropriate non-clinical services, including training, occupation and employment, were provided for de-hospitalized patients was recognized by psychiatric administrators early on. At the national level, Saskatchewan’s D.G. McKerracher pointed out in his 1961 study of psychiatric trends for the federal Royal Commission on Health Services that “after treatment psychiatrists discharge their patients from hospital with too little attention paid to their chances for future employment.”18 About that time, plans by psychiatrists to organize rehabilitation facilities under Health in Nova Scotia faltered because of the rivalry between the provincial government’s psychiatric bureaucracy and the university-based psychiatric profession.19 Nor did Health apparently pursue the plan mooted in 1969 by Arthur Shears, its specialist in rehabilitation medicine, to include facilities for discharged psychiatric patients in the new Nova Scotia Rehabilitation Centre which he was planning. When opened in 1977, it did not include the psychosocial, vocational division he felt would be needed to handle an increasing load of patients with psychiatric handicaps who would require therapy as inpatients in a rehabilitation centre before being placed in a sheltered workshop setting.20 Although Ralph Townsend, Health’s psychiatric administrator, admitted that support services in the community for former patients must provide, “not only good follow-up programmes to keep their mental condition stabilized, but also activities both social and vocational which will also help to do likewise”, those services were not developed under Health’s aegis.21

17 Morris to MacEachern, 3 October 1975, RG 72, vol. 119, no. 19.
19 Patrick Flynn, ed., Dalhousie’s Department of Psychiatry: A Historical Perspective (Halifax: Department of Psychiatry, Dalhousie University, 1999), pp. 76–77.
20 Shears to Paton, 29 January 1969, 18th meeting of the Provincial Advisory Council on Rehabilitation, 4 November 1969, RG72, vol. 73, no. 12.
In most cases the ex-patient was handed over to Welfare for community or quasi-voluntary institutional care with the assurance that clients experiencing acute episodes of illness could be returned to Health for treatment. As Townsend explained to the deputy minister of Health in 1982,

the Health system in Nova Scotia generally has shifted the long-term mentally ill or what is called the post-mentally ill to the Social Services system. At one time we had up to 1500 long-term mentally ill patients in institutions, whereas now we have less than 100. These are the more difficult and more seriously ill long-term patients . . . In effect, we have a small number of long-term inpatients but we continue to be a case-finding facility for Social Services and are dependent on Social Services to not only take patients from us, but also to develop services to prevent multiple re-admissions.22

Frank Wellard, the province’s director of rehabilitation, who made the transition from Health to Welfare along with rehabilitation services in 1968, put it more succinctly when he suggested that Welfare was more willing to recognize and meet health needs than Health was to meet welfare needs.23

Vocational rehabilitation in the community
Recognition was one thing; meeting needs quite another. For the provision of vocational rehabilitation programs Welfare and its cognate departments relied exclusively on private efforts, which meant the non-profit sector, there being no monetary profit from an agency’s point of view to be made in helping people with disabilities. The government’s subsidization of such programs was never generous and the agencies were therefore always reliant on their own charitable fundraising and that of the federated campaigns of the United Appeal. As charities they were not new to helping those in need. In Nova Scotia rehabilitation services for people with mental health problems developed out of the experiences of three non-profit, non-governmental agencies. One was the in-patient services

22 Townsend to Miller, 8 February 1982, RG 25, vol. 620, no. 3.
23 Wellard to McCurdy, 3 March 1967, RG72, vol. 27, no. 34. The significant extent to which the care of de-hospitalized mentally ill people in Nova Scotia was relegated to Welfare for residential care and rehabilitation appears to have been unusual in Canada. Richman and Harris noted this anomaly with respect to other provinces in 1983 when they commented on “an increasing shift of responsibility for the care, treatment, and rehabilitation of the long-term mentally ill from the Department of Health to the Department of Social Services. Alex Richman and Pamela Harris, ‘Mental Hospital Deinstitutionalization in Canada: A National Perspective with Some Regional Examples’, International Journal of Mental Health, vol. 11, no. 4, 1983, p. 72. Nor have circumstances changed in the 21st century. A recent report suggests that in the rest of Canada “the majority of mental health services are under the mandate of a Ministry/Department of Health”. Nova Scotia, 2008, Report of Residential Services, Department of Community Services, Services for Persons with Disabilities Program, p. 53.
available to varying degrees in mental hospitals under the aegis of the Canadian Mental Health Association. The White Cross volunteers of the CMHA began their hospital programs in the 1950s and their attention to social activities soon expanded to include a call for occupational therapy. By the late 1960s occupational therapy led to industrial therapy in institutions and even the initiation of trial transitional employment in the community for patients progressing towards discharge. While the CMHA was no longer part of institutional programming by then, it was highly respected by mental health professionals, including the therapists who were often active members of its branches where they became advocates for rehabilitation programs in the community.

A second agency instrumental in encouraging rehabilitation services, the Canadian Association for the Mentally Retarded, began as an offshoot of the CMHA designated in Nova Scotia as the Association for the Help of Mentally Retarded Children. Its members not only had an interest in getting their relatives out of the municipal mental hospitals but also in improving the opportunities for activities outside the Nova Scotia Training School. Perhaps because it was a parent-centred organization, it was more successful initially in convincing the government of the need to provide a better quality of life in the community for people with mental challenges than the CMHA was with respect of people diagnosed as mentally ill (as Harvey Simmons found in Ontario). However, the CAMR (later known as the Canadian Association for Community Living) could never distance itself totally from mental illness if for no other reason than the significant number of concurrent disorders found among children with intellectual challenges. The activity-focused facilities the CAMR promoted in the 1970s were open to people with mental illnesses, and were of particular benefit in the poorly served communities outside the Halifax metropolitan area.

The third non-governmental organization or, more accurately, type of organization, was that concerned with rehabilitation services for the physically disabled, especially crippled children, disabled veterans, and people with visual impairments, to name the most obvious. Ex-mental hospital patients also joined the queue for rehabilitation facilities developed by the physically-focused charities. The physical charities’ definition of disability was broad; people with physical disabilities often also had mental problems. In Nova Scotia the first such program, ostensibly for the physically disabled, that developed a broad clientele was New Leaf Enterprises, initiated in Halifax in 1960 under the aegis of the Junior League of Halifax, a young women’s service organization always on the cutting edge of community development, and the March of Dimes, the

charity then concerned with polio victims. New Leaf Enterprises later became a responsibility of the Nova Scotia chapter of the Canadian Rehabilitation Council for the Disabled (CRCD). Using both transitional and sheltered workshop models, New Leaf accepted as client-workers, in addition to those with physical disabilities, people with mental disabilities, reported at the time as including retardation, psychotic and emotional illnesses, and behavioural problems. The policy was “to accept those who can be conditioned or trained for normal employment.” A training program in offset printing qualified about four clients a year for employment outside its sheltered workshop and provided ancillary rote jobs in compiling, collating and addressing for another fifteen candidates for sheltered work. A ceramics program which produced items that were sold at the Atlantic Winter Fair employed about eight people, and a cleaning operation was initiated for others.

In 1970, in response to a recommendation of the Public Welfare minister’s advisory committee on rehabilitation, New Leaf’s management began a 30-day vocational assessment program. It was designed to evaluate the needs and capabilities of clients with respect to prospects for the workforce. Among the 95 clients referred by a wide range of agencies, the first year’s report identified twenty major disabilities, including 56 people with mental problems, the majority of whom fell into the retardation category. However between twelve and sixteen individuals were classified as being mentally ill. The report concluded that many clients were “in need of counselling and help in finding employment in the present labour market”. It also suggested that a minimum wage would be more appropriate than the customary $12 a week. Criticism of New Leaf was not always so constructive. Indeed the sheltered workshop concept encountered the same kind of hostility from private industry as prison labour had in the past. In

25 In 1985 it was renamed the Abilities Foundation of Nova Scotia.
26 Government would help through “the purchases of services if they meet satisfactory standards”. Comments by Kinnaird and Wellard on a guide for the study of sheltered employment, September 1962, RG72, vol. 11, no. 17.
27 Information regarding New Leaf Enterprises [May 1971], RG72, vol. 76, no. 2; CRCD Nova Scotia, executive director’s report for the year ending 31 October 1971, RG72, vol. 76, no. 3. New Leaf managed to continue its programming and expand its services despite attempts by Welfare to manipulate its organization and priorities. For example, Welfare attempted to make New Leaf merge with the activity centre for the mentally retarded. RG72, vol. 65, no. 2; Minutes, 4th meeting of the provincial advisory council on rehabilitation, 2 April 1968.
1972, the president of a major print shop in Halifax suggested that he would never consider hiring an employee trained by New Leaf Enterprises because it was an establishment that was competing with his business.  

Some evidence suggests that by the early 1970s Welfare considered that people described as mentally disabled were sitting up rehabilitation services in the province. Yet statistics kept by CRCD indicated that in 1974 only seventeen of the 7713 adults on the province’s disability registry were defined as mentally ill, though the number identified as mentally retarded totalled 2413. The criteria used to distinguish between the two types of disability are not revealed. Undoubtedly some of the latter people experienced dual disabilities or were “functionally” challenged because of institutionalization, rather than “congenitally” challenged. New Leaf was not deterred by the lack of sympathy displayed by business and government and continued to accept referrals of post-mentally ill people and to prepare its clients for the open labour market except for those for whom terminal sheltered positions were clearly indicated. Admittedly, the manager was occasionally discouraged by the hopelessness of some of these people, especially those with suicidal tendencies, and opined that New Leaf was becoming a “dumping ground” because such participants had “very little future in securing a job even if we train them to operate the equipment.” Before the peer-support movement such negativity was rife.

With the provincial rehabilitation authorities unhappy with the caseload imposed by individuals with mental disabilities, it is not surprising that experiments in rehabilitation continued to be the responsibility of the private, non-profit sector. Fortunately, the uncertainty implicit in the takeover of rehabilitation by Welfare was mitigated to some extent by the flowering of federal grant programs by the early 1970s. They were aimed at local communities and administered largely by the Department of Manpower and Immigration of the day, and although they were usually

30 Comments of Fred Hanson, president, Speedy Print Ltd. (1972), RG72, vol. 73, no. 18.
31 Wellard to Matthews, 7 December 1973, RG72, vol. 100, no. 20. On the transfer of non-medical rehabilitation from Health to Welfare, see MacKinnon to Directors, Regional Directors, District Supervisors, and Departmental Supervisors, Department of Public Welfare, 25 January 1968, RG72, vol. 27, no. 34.
32 Table, central registry of adults by county and disability, July 1974, RG72, vol. 102, no. 23.
33 Department of Social Services external consultant Catarina Versaeval made this distinction in her reports on residential facilities for the mentally disabled. Versaeval to MacKinnon, 21 May 1975; Versaeval’s position statement on “Facility X” individuals, 4 June 1975; Versaeval’s position statement on admissions and classifications, 4 June 1975, RG72, vol. 119, no. 20.
34 Housser to Thompson, 18 April 1974, RG72, vol. 111, no. 11.
designed as start-up or student projects providing only short-term funding, they did launch rehabilitation projects, often accompanied by a blaze of publicity. They included such job creation (later called employment development) programs as Local Initiatives (LIP), Opportunities for Youth (OYP), Local Employment Assistance (LEAP) Canada Works, and Outreach. They also largely bypassed the provincial authorities and thereby helped the financially strapped non-profit sector, including the CMHA, a tenacious organization that never experienced the kind of political impotency in Nova Scotia that Simmons found in Ontario.  

**LakeCity and mental health consumers**

Both the provincial division of the CMHA, with major branches in the Halifax metropolitan area, and the Trudeau-era “just society” programs contributed to the genesis of LakeCity. In Dartmouth, the city across the harbour from Halifax where the mental health services sector was a major employer, a White Cross social activity centre organized by the local CMHA branch opened in 1965. The programming was broadened in 1970 to include a craft and skill training program in a space separate from the socialization program. Under CMHA auspices, a group of enthusiastic young people took the program a step further when they secured an Opportunities for Youth grant in 1972 to set up a social rehabilitation facility for ex-patients. It offered training in life-skills including personal hygiene and appearance, basic cooking and nutrition, leisure time skills, and job hunting. In 1973 the two parts of the operation came together when the Dartmouth Activity Centre received as part of its funding a grant from the provincial Department of Social Services under the federal Vocational Rehabilitation of Disabled Persons Agreement and relocated to a better space. With half of the operating losses covered, the program organizers looked to a variety of local sources for the remainder, including the United Appeal, service clubs, trade unions, and other government sources both provincial and municipal. The Centre became a catalyst for new initiatives in the community such as the development of group homes in the Halifax-Dartmouth urban area and the establishment of the short-lived Rebound Industries (funded by LEAP) providing adapted employment in woodworking for high-functioning post-mentally ill persons.

36 Simmons, *Unbalanced: Mental Health Policy in Ontario*, p. 251.
37 William Gillis, Minister of Public Welfare, to Joan Merrick, president Dartmouth CMHA, 26 March 1973, and Expenditure sheet of Dartmouth Activity Centre, 1 April to 31 December 1973, RG72, vol. 102, no. 3.
38 The object of Rebound Industries was to create a self-sufficient industry adapted to the special needs of those with previous psychiatric disorders. See MacDonald to MacEachern, 26 October 1977, and Daley to MacKinnon, 31 October 1977, RG72, vol. 169, no. 6; Proposal to Metropolitan Mental Health Planning Board re Comprehensive Services for the Psychosocially
David Wright, the program director of the Dartmouth CMHA branch, was responsible for the centre’s outreach as well as its pioneering rehabilitation activities. By 1977 the client group included “individuals seriously disabled by previous mental illness and others whose abilities would befit them for ordinary competitive employment if it were available” to them in a form they could handle. They were people ranging in age from their early 20s to late 40s, some of whom had been members of the centre for over ten years and were still adversely affected by the experience of many years of institutionalization. In the absence of other services such as sheltered workshops, work training centres, and adapted industries, the staff of the Dartmouth centre did what it could to meet the requirements of a needy clientele but that meant they tried to be all things to too many people. The range of responsibilities undertaken by the small, overworked staff included assistance in finding jobs, searching for accommodation, providing legal advice, and referring clients to resources offered by other social agencies. Under the job-finding category Wright and his assistants supported the efforts of Manpower, advised prospective employers, directed clients to job-training opportunities supported by Manpower, and encouraged clients to participate in vocational assessment tests to determine their potential through such programs as the one run by New Leaf Enterprises.

In 1977 two men with considerable experience in CMHA work and community programming, Andrew Crook, the long-time executive director of the Nova Scotia Division, and Ken Jupp, Welfare’s coordinator of programs for post-mentally ill persons and a former CMHA director in Ontario, evaluated the Dartmouth Activity Centre for its major sponsor, the Department of Social Services. They found that social activities were undermining the vocational objectives and recommended that, to correct this shortcoming, the hours of the centre’s operations should be comparable to non-sheltered employment settings and personal development for clients needed to be more aggressively pursued. The next year under the supervision of Mike Arthur, the centre began to organize short-term volunteer job placements with local businesses to act both as a bridge to the job market and a test of the individual’s readiness for

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Disabled, 1 November 1977, Ad Hoc Committee on Community Activity Programs, Kelly Moyer, Chair (the Moyer Report), RG 25, vol. 616, no. 4. The emphasis on woodworking also occurred in a rehabilitation workshop for physically and mentally handicapped individuals in Truro in the early 1970s. This program was called JOBS (Job Opportunities through Basic Skills). See Brief to the federal Minister of Manpower and Immigration from the Nova Scotia Minister of Public Welfare [July 1972], RG72, vol. 76, no. 3.


40 MacIsaac to MacKinnon, 10 August 1977, RG72, vol. 169, no. 6.
that step. These measures also proved to be inadequate to the needs of clients. With Mike Arthur still at the helm, a sheltered workshop, which initially employed twelve people, was added in 1980. In an interview at the workshop, where table saws were buzzing and sawdust filled the air, Arthur suggested that CMHA wanted to promote “an environment which encourages good work habits and develops a skill”. The first work contract involved an order for 800 survey stakes. In addition the workshop made such articles as bird houses, spice racks, and book shelves for sale at Halifax County’s biggest flea market.

Well aware of the poverty and welfare dependency of their employees, the woodworking wage was set at $38 a month so as not to jeopardize social assistance payments. This small payment was nonetheless made by cheque in order to encourage familiarity with banking. The management also knew from experience that the sheltered environment would be more congenial to people who “could not cope with the normal pressures of a working experience” but would also help to integrate them into the rhythm and protocols of the open work world. In effect, this new workshop, named LakeCity Industries, replaced the defunct Rebound operation, as well as a Canada Works-supported sheltered program started by the Halifax branch of the CMHA in 1977, which specialized in the repair of small appliances. Although Geoffrey Reaume has argued that the social assistance system which condoned a pittance for wages was unchallenged by proprietors of sheltered workshops, LakeCity’s decision to work within the system was pragmatic. A principled stand in support of pay equity with the competitive workplace for clients overwhelmingly supported by state welfare would have ended the operation in no time at all.

Its initial designation, LakeCity Industries, captured the organization’s orientation toward teaching practical skills to those able to benefit from such training, and thus to be “rehabilitated” in order to enter, or re-enter, the conventional workforce. In the event, LakeCity came to provide far more than this and is, therefore, an interesting, if somewhat

42 Reg Horner, “More space sought for sheltered workshop”, Dartmouth Free Press, 11 June 1980. The article refers to a wage of “about $40”; Chris Fyles claims that it was $38. Fyles to Fingard, 15 July 2010.
atypical example of a program which has evolved to meet the changing needs of its particular clientele, thus retaining its value and relevance. LakeCity makes a compelling study because of the success of its programs, measured in terms of longevity, adaptability, and diversity; the clarity of its vision; and the dedication and imagination of those involved. Unlike other rehabilitation programs which focus on people with intellectual disabilities, and which include people with a primary diagnosis of mental illness only incidentally, LakeCity has concentrated on those much neglected individuals who are emerging from the fog of psychotic or depressive episodes, especially schizophrenia, as well as persons in that "grey area associated with attention deficit and learning disabilities".44

During its association with the Dartmouth branch of the CMHA, the program, was run by a committee from a house on Prince Albert Road in the downtown. However, by 1982, it had begun to spend more than was contained in the branch’s budget, and threatened to overwhelm its other activities. Accordingly, the committee formed a board, and LakeCity was incorporated as an entity separate from CMHA.45 When the province refused to fund renovations to the Prince Albert property that year, where the workshop was bursting at the seams, the newly constituted organization moved to its present location on Windmill Road in north Dartmouth, close to a large industrial park, suitable for a production woodworking shop and a retail outlet for the sale of the furniture manufactured there. In April, Chris Fyles was hired to serve as its director. With bachelor’s degrees in music and education and experience as a technical director in the theatre, he brought with him no formal training in the area of mental health. He was skilled as a woodworker, however, and was able to continue training LakeCity’s clientele in an area of potential vocational utility. LakeCity has been fortunate in its acquisition of staff. In 1989, Fyles was joined by Bob Jollota, who had, if anything, an even more eclectic background. Upon completion of a degree in philosophy and psychology, he pursued a variety of jobs, including employment at a health food store and restaurant, a stint in the coast guard, and experience as a taxicab driver. He then took a precision woodworking course after which he learned production woodworking in commercial establishments. Because the operation was expanding, LakeCity required someone to oversee the manufacture of the furniture line which had, by that time, become its trademark. Jollota had the necessary skills and stayed on as

44 Information provided by Chris Fyles, the executive director of LakeCity, 1982 to present. This description of LakeCity’s thirty years of operation is based largely on an interview with the executive director and the two employment coordinators as of 2009 (interview, 28 October 2008) and on correspondence with Chris Fyles in 2010. See also www.lakecityemployment.com.
an instructor after the addition to the premises was completed. The third person associated with the more recent history of LakeCity arrived on the scene in 1997 and stayed for twelve years. Dave Rideout, a psychology graduate, had previously worked for five years at the Waterford Hospital, the major psychiatric facility in Newfoundland, before moving to British Columbia where he coordinated an employment program for people with mental health problems, and taught life skills at the University College of the Fraser Valley to those experiencing difficulties obtaining employment. He brought to LakeCity his practical experience of working with troubled people. Arguably this combination of individuals with very diverse backgrounds, skills, and experiences but with a common interest in the welfare of people self-identifying as mentally ill may, in retrospect, explain the direction along which LakeCity evolved.

When Fyles joined LakeCity, clients were producing survey markers for the Department of Transport and relatively crude but solid “slat furniture”, such as end tables and coffee tables, for sale to the public. At that time, there were four staff and twenty clients, with a waiting list of others wishing to access the program. With his experience in woodworking, Fyles set about improving the quality of the product while at the same time providing employment and training to a potentially expanding workforce. Jollota’s addition to the program strengthened the product line at LakeCity Woodworkers, which now included the high quality retail and custom furniture that remains the mainstay of LakeCity’s commercial activities. In an effort to expand and diversify, and to provide relevant experience to a wider range of clients, LakeCity also opened a computer re-cycling shop called ReBOOT, which is part of the national program ReBOOT Canada, and, most recently, a ceramics and fused glass manufacturing facility called Creative Fire Studio. Until recently participants in the onsite programs were paid a monthly wage of $150, the maximum then allowed by employment support and disability programs. This was sufficient to recognize their efforts and help with minor expenses, but not so great as to interfere with the social assistance on which they primarily depended. While some critics see such remuneration as a “disincentive” that discourages pride in the work and encourages fear of exploitation, the shops provide a form of experience without which few mental health consumers would be able to enter the competitive labour force.

As with its predecessor programs, LakeCity continued under the general oversight and support of Welfare. Its funding, over and above the revenue from the industries, was secured from all levels of

46 For ReBOOT’s national work see www.rebootcanada.ca/.  
government—municipal until the assumption by the province of all municipal public welfare responsibilities in the mid-1990s; provincial by virtue of the rehabilitation policy adopted in the mid-1960s; and federal as part of a series of national programs for persons considered disabled dating back to the mid-1950s. With the cessation of municipal grants, help from the city took the form of partial relief on property taxes. A new era of funding has recently occurred with the end in 2010 of federal support from Service Canada and transfer of that responsibility to the Employment Nova Scotia division of the Nova Scotia Department of Labour and Workforce Development. For many years, LakeCity also received funds from the United Way although that is no longer the case.

In the meantime, by 1988, Fyles and Jollota recognized that at least some of those working at LakeCity had acquired skills which might make it possible for them to seek employment in the community, thus reducing their reliance on the workshop (and possibly welfare) while, at the same time, freeing LakeCity to take in more people in need of its assistance, including more women who were not appropriately served by the industrial operation. This marked the beginning of what became LakeCity Employment Services Association, which emerged as the main service provided by LakeCity. Initially, clients were referred to training programs at Dartmouth Work Activity and Haltrans Industries, from which they might be expected to obtain jobs outside the sheltered confines of LakeCity. This first attempt at job placement was not completely satisfactory, as some of those who had seemingly moved on soon reappeared at the parent workshop with the expectation of resuming where they had left off. The experience led Fyles to re-evaluate the needs of his clientele and prompted him and his co-workers to adopt a model of “supportive employment”. Developed in the United States for people with intellectual disabilities, this concept was adapted to suit the needs of those coping with mental illness or its aftereffects.

As practiced at LakeCity, supportive employment, in which both Jollota and Rideout trained to serve as employment coordinators, is a client-centred approach which defines “work” in very broad terms. Individuals determine what it is they wish to do to become re-engaged with the community. This may range from non-remunerative volunteer activities (participants in the program have served at the divisional office of the CMHA, for example) to paid employment in a variety of settings for varying periods of time (one university graduate we interviewed took a library job for a year with LakeCity’s help), to enrollment in education or training programs. The staff attempts to match the mental health consumer’s description of what she or he wants to do with a suitable agency or

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48 Haltrans was started by the Halifax branch of the CMHA in the mid-1980s. Its legacy is Stonehearth bakery. See www.mymetroworks.ca/.
employer and then serves as the conduit through which contact between the two is established. Even the Project 50 that the Department of Community Services took over from the municipal social planners can be organized through LakeCity. This program helps de-hospitalized persons make the transition to community by encouraging them to perform tasks likely to help build their self-esteem. For this part-time, individually tailored work, contracted with an approved agency like LakeCity, people with disabilities receive a token monthly government supplement of $50.

It was early recognized that a client’s confidence as an employee would depend upon continued support. Staff followed the individual’s progress at his or her chosen activity to ensure that the client was developing the appropriate work skills, attitudes, and habits, and had the necessary basic needs in the form of housing, food, and transportation to function productively in the workplace. From a practical perspective, this involved LakeCity personnel in a very wide variety of support roles. For example, “work skills” might simply be “life skills” adapted to the workplace. Grooming, dressing properly for the setting, arriving on time and staying until the end of the work day, interacting in a productive fashion with one’s fellow workers were all matters which staff oversaw, without being intrusive. Money management could be a particular challenge for someone who had been institutionalized and who was not acquainted with how government services operate. LakeCity personnel developed particular expertise in “navigating the system” to ensure that their clients did not “fall between the cracks”. Clients were on social assistance of various sorts; staff knew which agencies were involved (Community Services, Pharmacare, CPP), what kinds of assistance were available (Employment Support and Income Assistance, Disability, supported housing), what people were allowed to earn without jeopardizing their support, and what drug plans might apply. Clients were taught to use the support system in order to promote the likelihood of success in the workplace. LakeCity staff did not attempt to teach the specific skills associated with a given job, nor did they substitute for someone who had to take leave from a particular placement. However, clients were always able to return to the woodworking or other programs at the workshop, with no time limit imposed on their eligibility to do so. In this sense, LakeCity also served as a backstop for those who found themselves in difficulties. There is at least one instance of a person who had been back and forth between the community and the woodworking program for a period extending over twenty years; others came in once, then left and did not return at all.

Recent statistics reveal that the employment services division had about 400 clients, with eleven new clients coming to them every month, and a placement rate of twelve jobs a month. The on-site industries accommodated about fifty workers. Referrals to the program came through health and welfare professionals, but in particular those who worked most
directly with mental health consumers, especially occupational therapists and psychiatric nurses. LakeCity’s commitment to helping people with mental illnesses meant that its own staff (job counsellors, administrators, etc.) included mental health consumers to the extent of about 28 per cent in 2010. The service therefore made a significant contribution to the peer-support movement.

Surprisingly, aside from such mental health practitioners as nurses and occupational therapists and its own client base, LakeCity is still not well known. This is particularly unfortunate with respect to the psychiatric profession which continues to be the most influential element in the professional mental health hierarchy. However, rather than suggesting tension between medical and psychosocial approaches as identified by Leona Bachrach, the disconnect in Nova Scotia is more symptomatic of poor coordination of mental health services since the 1980s and evidence of the “silos” deplored in such recent studies as Ontario’s “Every Door is the Right Door.”

Table 2: Employment Statistics for LakeCity 1989–2008

<table>
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<tr>
<th>YEAR</th>
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<th>VOLUNTEER POSITIONS</th>
<th>EDUCATION</th>
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LakeCity has attempted to expand its activities beyond the Halifax urban area, although the largest proportion of mental health consumers in the province undoubtedly resides there. From long experience, LakeCity was well aware of the paucity of employment services outside the metropolitan area and the challenges faced by people with disabilities living in rural areas. As an experiment in outreach, the TREES program (Training, Recovery, Employment and Empowerment Services) was established in 2006 to provide employment counselling to people living in the Colchester-East Hants area, a central region of the province north of Halifax Regional Municipality (HRM) with a CMHA branch and psychiatric services.\footnote{Started as a pilot project through CMHA headquarters in Truro in 2005, TREES was well enough established to be on the agenda of the CMHA National conference in Dartmouth in 2008 as a workshop presentation, “Employment Support: Opportunities and Challenges in Rural Nova Scotia”, 23 August 2008.} Difficulties of communication and transportation occasionally hampered the ability of employment counsellors to contact and aid those who, because of poor mental health, had difficulty finding suitable jobs or accessing services. Experience with this program showed that there were a larger number of such people than might be expected, but equally that there were more job opportunities than the setting would suggest. Living in a region consisting of small towns has its advantages in the form of “natural supports in the community”, coupled with the inevitable disadvantage of a lack of privacy. Once employed, however, mental health consumers might be better accepted and more favourably viewed by their neighbours, as they were seen to be contributing to the community rather than relying on it. Notwithstanding the difficulties of running an employment service in a rural setting, the Colchester-East Hants program was able to place thirty-nine people in jobs in the first ten months of 2009. Recently the rural reach of LakeCity has also been extended to rural areas of HRM itself.

The “supportive employment” model for vocational and psychosocial rehabilitation, combined with the conviction that recovery is a realistic goal, has guided LakeCity’s approach to helping those dealing with mental afflictions both in its central and satellite locations. This journey of recovery includes a program of employment based on the client’s definition of what she or he wishes to accomplish. In this regard, Dave Rideout commented:

We are firm believers in choice and so it is not our role to tell somebody what to do...Our role is to provide them with information. Clients will tell us what they want to do and we in turn will point out all the pros and cons. It is incumbent on us to have all the information we need to accurately give the client information they need for making an informed choice.
At the end of the day, they make that choice. We may disagree with the choice and not think it is a good choice but whatever they choose we will provide them all the support we can. We (or at least I) have been proven wrong lots of times. I might say there is no way this is going to work and sure enough it does work. There is nothing better than that this should happen to you.51

This faith in the client’s ability accurately to assess and articulate goals and competencies is itself an empowering attitude, a first step in restoring self-confidence, where that is needed, and in establishing a trusting relationship between staff and mental health consumer. It demonstrates respect for an individual’s wishes, and indicates a willingness to accept and facilitate whatever course of action the consumer decides to pursue. Once undertaken, an activity, whether it be paid employment, volunteer work or education, creates a milieu in which the client may experience an increased feeling of self-worth, a sense of place in society, and a growth in personal dignity. Supportive employment, as conceived by LakeCity, is non-ideological and non-judgmental. A client’s success in the program is measured by personal outcomes. “Recovery” is therefore not assessed in absolute terms, but rather in terms of the improvement, however great or little, that a consumer experiences in quality of life, as exemplified by LakeCity’s slogan: “Improving quality of life through work.”52 This is a much more rational and hopeful approach to measuring recovery than is achieved by imposing some normative standard applied to everyone regardless of circumstance. Indeed, “mental illness” conventionally defined can, in this framework, be perceived as an issue secondary to the business of identifying strengths that will help in the workplace and weaknesses that can be alleviated through job counselling. LakeCity employment coordinators “build the job around their abilities, not their mental health, and then cope with the mental health issues” as best they can.53

The efficacy of employment, broadly defined as it is at LakeCity, for people traumatized or impeded by the nature of their illness has long been recognized. It was part of the moral treatment of the asylums of the 19th century; it helped to rehabilitate war-damaged veterans of the last century’s world wars; it launched a new profession in the second half of the 20th century; it was introduced in the traditional mental hospitals first as occupational and then as industrial therapy in the 1960s and 1970s. We can see organizations like LakeCity as the community’s response to the need for vocational rehabilitation or more often

51 Interview, 28 October 2008.
52 A slogan that appears on the masthead of LakeCity’s website.
53 Interview, 28 October 2008.
“habilitation” for the “post-mentally ill” or, in the current parlance most accepted in Nova Scotia, “mental health consumers”. By adopting faith in the concept of recovery and a flexible, respectful approach to the client’s vocational goals, LakeCity folk have been providing for thirty years a much needed service. From the government’s perspective, reliance on the NGO non-profit sector has been a cost-effective (i.e. cheap) solution to care delivery.

Although it could be argued that LakeCity is an institution imposing social and community norms on its clients, the support it provides differs materially from that associated with traditional psychiatric institutions. It is not a physical institution for most of its clients; it is not a place of confinement for any of them. Because it tries to integrate people into the wider society either through work or preparation for work in the community, it does not separate people with mental illnesses from those who enjoy good mental health. Undoubtedly, it is a support system attuned to the needs and wishes of the people it serves and thereby functions as an open asylum for troubled people. It may therefore be appropriate to expand the definition of an institution to include structured support systems that operate outside a defined locus and seek to engage the consumer with the community as LakeCity has successfully been able to do.

Conclusion
With the benefit of hindsight we can see that in the development of community programs to replace long-term institutionalization, the architects of the welfare state faltered. For the most part Health did not embrace the chance to offer non-medical services. As the overseer, but not the provider of services in the community, Welfare acted as the conduit for the minimal level of resources available through the Canada Assistance Plan and the “just society” programs. The participation of other government departments at all levels remained secondary to Welfare, under whose scrutiny the bulk of the public funding for new initiatives was turned over cautiously and parsimoniously to non-governmental agencies. Most of them operated on a non-profit basis, often with charitable status, under the oversight of volunteer boards. They drew on their experience of donating services to patients in the old institutions and applied pragmatic and client-centred principles to rescue the older, deinstitutionalized folks and to empower the younger, intermittently hospitalized ones. Their belief in a recovery model, together with the adoption of psychosocial rehabilitation concepts, put the interests of the mental health consumer first. As a result of their client-centred policies for people with mental disabilities, community organizations, including peer-support groups, became responsible for the everyday mental health of their clients.
The development of employment opportunities featured prominently in the routine services provided by these non-profit organizations. Entry into the workplace either on a volunteer or paid basis provided a chance for the person with a mental disability to interface with the working world. As a result, “post-mentally ill” individuals in recovery met other people in a conventional work-a-day setting where the distance, preconceptions, and stereotypes diminished as social bonds were established. As work is a criterion by which a person’s worth is often assessed by society, the capacity of the mental health consumer to perform useful activities served to legitimize that person’s value in the public eye, break down stereotypical views, and educate the public about the potential of people living with disabilities. Moreover, in their hiring of individuals with disabilities, referred by sympathetic employment agents, employers demonstrated their faith in a worker’s ability to perform effectively an assigned task rather than anxiety that a person’s medical history preordained failure.