The Vitality of the English-Speaking Communities of Quebec: From Community Decline to Revival

Edited by: Richard Y. Bourhis

Published in partnership with the:

Centre d'études ethniques des universités montréalaises (CEETUM),
Université de Montréal
and
Canadian Institute for Research on Linguistic Minorities (CIRLM),
Université de Moncton

Montréal, February 29, 2008

Please cite this chapter as follows:

Carter, J. (2008). What Future for English Language Health and Social Services in Quebec? In R.Y. Bourhis (Ed.) *The Vitality of the English-Speaking Communities of Quebec: From Community Decline to Revival*. Montreal, Quebec: CEETUM, Université de Montréal.

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Preface

Richard Y. Bourhis
Director, CEETUM, Université de Montréal
Département de Psychologie,
Université du Québec à Montréal (UQAM)

« La démocratie ce n'est pas la dictature de la majorité, c'est le respect des minorités »
Albert Camus

The goal of this book is to provide a current portrait of the group vitality of the English-speaking Communities of Quebec. The enduring stereotype about the Anglophones of Quebec is that it is a pampered minority whose economic clout is such that federal or provincial support for the maintenance and development of its institutions is hardly necessary. This view of the privileged status of Quebec Anglos is widely held not only by the Francophone majority of Quebec but also by many leaders of Francophone communities across Canada. On the few occasions that Anglophones in the rest of Canada (ROC) spare a thought to the Anglophones of Quebec, either this idealised view of the community prevails, or they are portrayed as residents of a linguistic gulag whose rights are trampled on a regular and ongoing basis.

We cannot blame Francophone minorities outside Quebec for envying the institutional support and demographic vitality of the Anglophone minority of Quebec. Why should Francophone minorities outside Quebec feel they have to share precious federal resources with Quebec Anglophones who are doing so much better than themselves on the institutional support front? The first obvious response is that government support for official language minorities is not a zero-sum game and that evidence based needs should be sufficient to justify the maintenance and development of both Francophone and Anglophone communities in Canada and Quebec. The second complementary response is that the institutional support achieved by the Anglophones of Quebec during the last two centuries can be used as a benchmark goal for the further development of Francophone minorities across Canada. The combined efforts to maintain and develop the vitality of the Francophone communities outside Quebec and of the Anglophone minority within Quebec, contribute to the linguistic and cultural diversity of Canadian and Québécois societies.

But what is the current vitality of the English-speaking communities of Quebec? Taken together, the chapters in this book tell a sobering story about the decline of this historical national minority in Quebec. On the status, demographic and institutional support fronts, Quebec Anglophones are declining, especially in the regions of the province but also in the greater Montreal region. Though much of the chapters are devoted to documenting the ups and down of this decline, some effort is made in each chapter to propose options and strategies to improve and revive the vitality of the English-speaking communities of Quebec. We hope this book, along with past and future ones, will be used by Quebec Anglophones as a tool to develop their community vitality in the present and for the sake of future generations. It is also hoped that this book will inspire Quebec decision makers to pay more attention to the vitality needs of Quebec Anglophones, a minority community who contributed so much to the social, cultural and economic development of Quebec society.

Finally, a word of thanks is owed to all those who made this book possible. The editor and chapter contributors wish to thank in particular the following: the Canadian Institute for Research on Linguistic Minorities (CIRLM), the Quebec Community Group's Network (QCGN), the Department of Canadian Heritage, and the dedicated staff of the Centre d'études ethniques des universités montréalaises (CEETUM) at the Université de Montréal.

WHAT FUTURE FOR ENGLISH-LANGUAGE HEALTH AND SOCIAL SERVICES IN QUEBEC?

James Carter
Community Health and Social Services Network (CHSSN)

The chapter examines six dimensions for considering the future for English-language health and social services in Quebec. A historical overview of legislative guarantees of services in English presents two opposing political perspectives on their application, as well as community mobilization efforts required to protect the legislation. Recent information on demographic vitality and health status of English-speaking communities sets an important context for understanding the regional realities of access to health and social services in English. The new context of Quebec's health and social services system is described with respect to its impact on access programs of services in English. The results of the 2003 federal Action Plan for English-speaking communities are presented, as well as the community blueprint for action aiming to secure the future of English-language health and social services in Quebec.

1. Legislative guarantees of services in English: Historical overview

The right of English-speaking persons to receive health and social services in the English language is inscribed in the legislation governing Quebec's health and social services system. Part of an answer to the question about the future of services in English lies in taking a fresh look at the impact of the legislative guarantees on the service delivery system, on government policy guiding system reforms, and on English-speaking communities.

A historical perspective is required to understand how the guarantees, won almost twenty-five years ago as a result of community mobilization, have survived political pressures and major system reforms. The story is instructive because the legislative provisions prescribe the actions of a broad range of actors that include public institutions, communities and the Quebec government with respect to application of the right to services in English within the health and social services system.

The impetus for the 1984 community campaign for legislative guarantees came from a government proposal to regionalize and sub-regionalize service delivery. The plan called for transfers of personnel from the flagship English-language social services institution in Montreal to a developing network of local community service centres (CLSCs). The reorganization was considered a threat to the ability of the network of English-language health and social services institutions to continue to serve English-speaking communities. In addition, there were no guarantees that the new services in the CLSC network would meet the needs of English-speaking people. Eric Maldoff, President of Alliance Quebec, laid down fundamental principles to be included in the reform at a press conference in November 1984.

> *Our community must be guaranteed access to social services in our language. There can be no treatment without communication. Failure to provide this essential guarantee is nothing less than overt exclusion of the English-speaking community from universal access to social services.*

Bill 142, introduced by the newly elected Liberal government, was assented to on December 19, 1986. The Bill amended the existing health and social services legislation to provide a qualified right for English-speaking people to receive services in English. It directed regional planning authorities to develop access programs of services in English, taking into account the resources of the institutions in each region. The Bill provided for the designation of certain institutions (generally those historically affiliated with English-speaking communities) permitted to offer their range of services in English. It is important to note that this "bilingual status" in no way exempts them from the obligation to ensure all their services are accessible in French as prescribed by Quebec's Charter of the French Language.

Since 2003, the legislative guarantees have worked relatively well at the administrative level. Collaboration among the various government, institutional and community constituencies is leading to a new generation of access programs of services in English to be approved by the government this year. Because serious political debate over the legislation has been dormant in the recent period, there has been a natural tendency to relax 'political preparedness' and concentrate on other priorities driven by system reforms and community development needs. What elements in the previous political debate are likely to shape a new debate, if it emerges? What action is merited to ensure the legislative guarantees continue to play their crucial role?

The legislator's intent

Key political positions taken by the Liberal government in the initial debate were later instrumental in guiding administrative actions within the system that led to government decrees enacting the entitlement of services in English. These political arguments remain highly relevant, because they continue to dominate the legislation, policy and administrative processes related to enacting the right to services in English within the system. An excellent legal and political analysis of the legislative guarantees is presented in Silver (1999) and cites extracts from the National Assembly debates outlining the opposing political views. Thérèse Lavoie-Roux, Minister of Social Affairs and responsible for piloting Bill 142 through the National Assembly in 1986, defined the Liberal government's intent in the following manner:

> *What we want to do (…) is guarantee the exercise of a right; confer in a law the right of the minority to receive services in its language in the health and social services domain. A right that is not constitutionally or legally recognized does not have real operational effect.* (Translation)

Pierre-Marc Johnson, leading the Parti Québécois debate, expressed the following view of the 'right of the minority':

> *When one discusses linguistic questions (…) you must have in mind that there is no symmetry or reciprocity between the Anglophone minority of Quebec and the minorities outside Quebec that are Francophone. (…) This debate has launched around something that is essentially a collective right and not rights of the individual (…).* (Translation)

More difficult to challenge was the argument of language as a tool of service delivery presented by Thérèse Lavoie-Roux:

> *The central question is to recognize the relationship (…) between the provision of health services and social services, and (…) the language in which these services are delivered. Concretely, the provision of services encompasses the range of gestures and actions that constitute the tissue of communication between the provider of services and the beneficiary. It is not simply a question, in this domain, of posing gestures or techniques; but the service provider must, in the first order, enter into communication with the beneficiary.* (Translation)

In 1989, the government adopted the first access programs. This followed a decree the previous year designating certain institutions that would offer all their services in English (as well as in French). An agreement was also signed with the Government of Canada, providing a financial contribution to Quebec's initiatives to improve access to services for English-speaking communities. These actions effectively integrated the right to services in English into the normal functions of the health and social services system. This state of affairs continued through Liberal reform of the system in the early 1990s. The legislative guarantees were instrumental in protecting the right to services in English during reorganization, as well as securing the mandates of institutions historically affiliated with English-speaking communities. In addition, an important amendment was adopted creating provincial and regional advisory bodies that formalized the community role in advising the government and regional planning authorities on the provision of English-language services.

However, this period of orderly implementation of the guarantees ended in 1994 with the election of a Parti Québécois government. Over the next nine years, two major events changed the political and administrative context of implementation of the right to services in English. The first was a radical transformation of the health and social services system, and the second was a government sanctioning of the introduction of language politics into the delivery of services in English.

The Parti Québécois Government of 1994-2003: Transformation without guarantees

The network transformation was designed to respond to emerging demographic and cost pressures on the health and social services system. The amalgamation and closure of institutions were key features of the reform and deemed to have a serious impact on the right to services in English. At issue was the government's preference to treat the right as a secondary matter, to be taken into consideration once reorganization was completed. At this point, the statutory revision of the access programs had been held up for several months; and services legally recognized as providing English-language services were being closed, merged, transferred, or dispersed without any concrete plans to ensure access to services in English. It was a situation reminiscent of the precarious status of English-language services prior to the adoption of legislative guarantees. In a letter of April, 1996, to Jean Rochon, Minister of Health and Social Services, the Provincial Committee stated the following:

> *(...) We must signal our grave concern that transformation plans are failing to recognize the special role and responsibility of the network of English-language institutions. Furthermore, these plans are putting into question the future of services accessible in English which are on the verge of being identified in French-language institutions affected by transformation.*

The Parti Québécois and language politics

The legislative guarantees were also coming under scrutiny as part of a government review of the status of the French language in Quebec (Silver, 1999). An inter-ministerial committee reporting to Louise Beaudoin, Minister responsible for the Charter of the French Language, stated that the broad definition in the law of "English-speaking person" gave all Quebecers the right to seek services in English. This challenged the Parti Québécois government policy to make French the official public language of Quebec and was seen as promoting institutional English-French bilingualism by allowing 'freedom of choice' in the use of public services.

Soon after the Parti Québécois election victory, Premier Lucien Bouchard addressed the concerns of Quebec's English-speaking communities in a key speech at the Centaur Theatre in Montreal. On the issue of access to services in English, the Premier declared that a person going for a blood test should not also require a language test. Despite this, the ruling Parti Québécois party platform was

amended to include a review of the health and social services legislation to ensure institutions would not fall prey to functional or institutional bilingualism as a result of application of legislative guarantees granted to the English-speaking minority.

Early in 1997, the government sent the access programs to the *Office de la langue française*. This was considered by English-speaking communities as an assault on their legislative guarantees. It added further delays to government approval of the access programs. The regional boards (planning authorities) were required to justify their addition of English-language services to the programs; and the *Office de la langue française* concluded that the access programs did not provide an adequate evaluation of their impact on the Charter of the French language (Silver, 1999). The Ministry of Health and Social Services hired outside consultants to analyse the access programs. Their conclusion was that "organizational factors" would lead to an increase in the number of institutions offering services in English.

A report on the access programs went to the Quebec Cabinet in July 1997 and drew this response from the Deputy Premier, Bernard Landry:

> *We received a report from the Ministry of Health that was totally unacceptable, and that went too far. The number of bilingual institutions has absolutely no relationship with real needs of the Anglophone minority. This makes us more vigilant (…) It includes nearly half the institutions in Saguenay-Lac-Saint-Jean (…) That is unacceptable. The proportions are not right and all must be reviewed in depth.* (Translation) (O'Neil, Le Devoir, July 19, 1997)

"Enough is enough": taking the government to court

In January 1999, Alliance Quebec issued a writ of mandamus against the Parti Québécois government charging that it had failed to respect the legal delay for approval of the access programs identifying services available in English. This legal action triggered the Cabinet approval process and the English-language services plans were finally adopted by the government in 1999.

But the story did not end there. In November 2001, the Minister of Health and Social Services, Remi Trudel, stated that the number of bilingual posts with health and social services institutions had to be reduced. At the same time, a confidential presentation of his Ministry of Health and Social Services to the Larose Commission on the status of the French language cited dangers of the legislative guarantees of services in English and expressed the wish that the health and social services law "regain its virginity" in a manner so that the network be "liberated from this strange body (legislative guarantees)" (David, Le Devoir, January 22, 2002). (Translation)

In the face of public criticism by the Liberal Party opposition, English-speaking communities and Francophone media, the Minister backtracked saying he would publish a "new policy" in the spring, after consultation with the Provincial Committee. However, there was a problem, as the Committee members had resigned in December 2001 declaring a lack of confidence in the government's handling of the legislative guarantees.

Over a year later, in March 2002, leaders of English-speaking communities, under the auspices of the Quebec Community Groups Networks (QCGN), confronted Premier Landry at a meeting on the government's intentions regarding access programs of services in English. The Premier replied that there would be a moratorium on any further action by the government. With the defeat of the Parti Québécois government in 2003, a difficult period for Quebec's English-speaking speaking communities drew to a close.

A lesson in "political preparedness"

When the contrary political views challenging the Liberal adoption of Bill 142 eventually shaped government policy in the mid to late 1990s, the results led to political and administrative actions that were challenged by English-speaking communities.

When the less tolerant political views of the Parti Québécois government began to have a serious negative impact on the implementation of service guarantees, English-speaking communities organized to respond. Many community leaders involved in mobilization at the time felt that the relationships established between English-speaking communities and the health and social services system, as a result of legislative guarantees, served to buffer many (but not all) of the effects of Parti Québécois government actions perceived as diminishing the right to services in English. It was also felt that legal action against the government was required to force its compliance with the law. It is always possible that elements of the previous political debates regarding English-language services guarantees will surface again. Community mobilization may again be necessary, if past history is any indication. It would seem that "political preparedness" should come back on the agenda of English-speaking communities. This means that energy and resources must be devoted now to create a renewed policy capacity that can rally the key constituencies and prepare for any future debate on the status and legitimacy of English-speaking communities and the rights that support them.

2. Demographic vitality and determinants of health status of English-speaking communities

Declining and aging communities

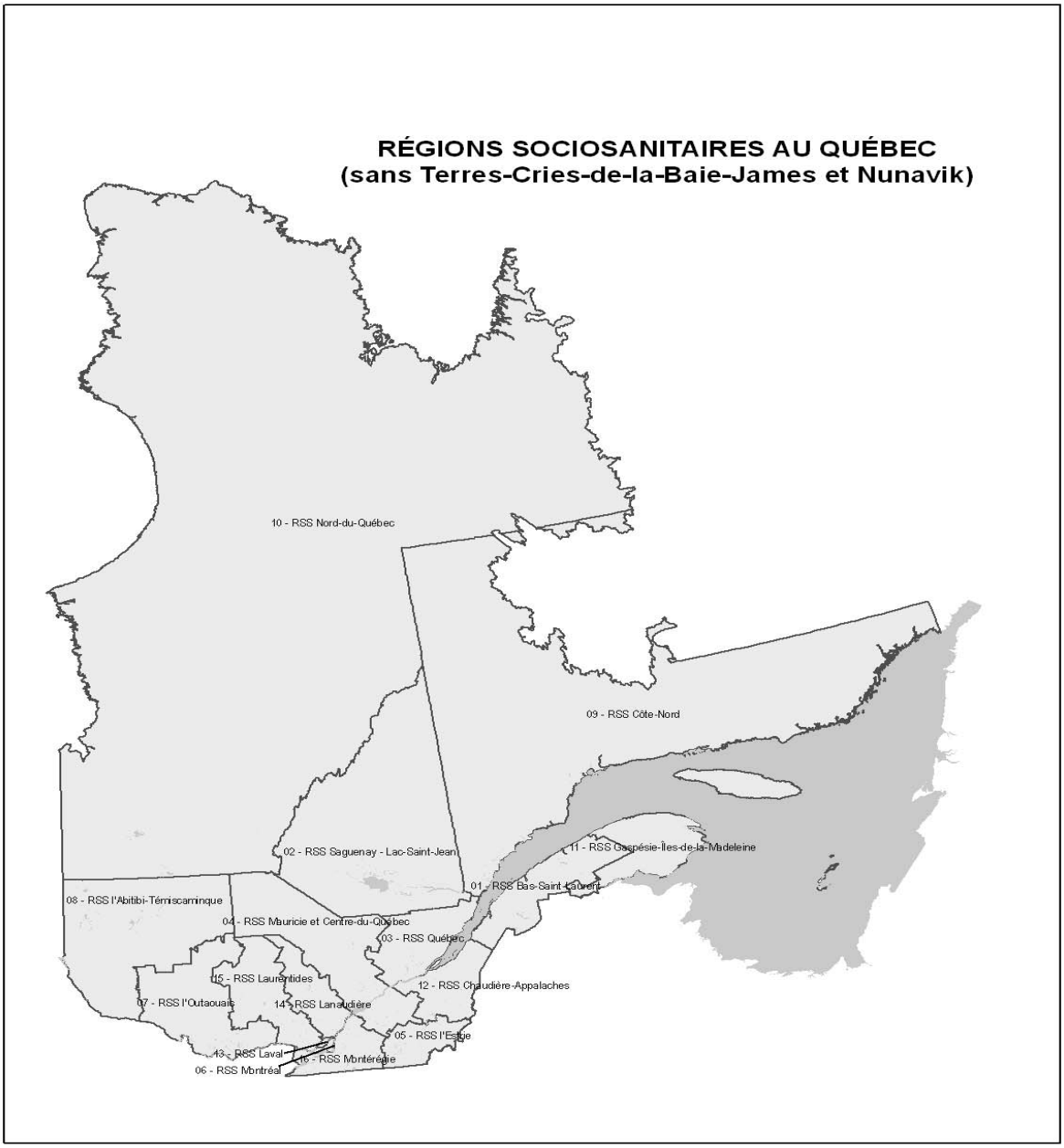
English-speaking communities of Quebec experienced the largest demographic decline in absolute numbers of all the official language minority communities in Canada between 1996 and 2001 (CCESMC, 2007a). Within Quebec, English-speaking minority communities declined in fourteen of seventeen administrative regions; with dramatic declines in five regions, where populations dropped by over 13% in the five-year period.

English-speaking communities are aging at a faster rate than the French-speaking majority communities in thirteen of seventeen administrative regions. The proportion of seniors aged 65 and older relative to the whole English-speaking minority community was over 20% higher than the proportion of Francophone senios in their communities. As a consequence of aging, these communities have smaller proportions of youth, as well as adults in the age range of 40 to 59, when compared to the Francophone population. The adult group is called the 'caregiver' generation because of its social role in caring for the aging population. This shrinking group in many English-speaking communities is creating more vulnerability for seniors, as social support networks weaken.

Determinants of health: income, employment and social supports

Income, employment and social support networks are key determinants affecting health status (CCESMC, 2007a). Understanding how English-speaking communities fare with these indicators is an important element in identifying needs and priorities (see Floch and Pocock, this volume). English-speaking Quebecers are 26% more likely than the Francophone majority to have incomes below the Statistics Canada low-income cut-off. The rate of low income in English-speaking communities is greater than that in Francophone communities in 15 of 17 administrative regions.

Certain population groups are at greater risk of experiencing health problems. Close to 43% of unattached English-speaking individuals live below the Statistics Canada low-income cut-off. Lone parent families are vulnerable with respect to income security. While 33.7% of Francophone lone


RÉGIONS SOCIOSANITAIRES AU QUÉBEC
(sans Terres-Cries-de-la-Baie-James et Nunavik)
10 - RSS Nord-du-Québec
09 - RSS Côte-Nord
11 - RSS Gaspésie-Îles-de-la-Madeleine
02 - RSS Saguenay - Lac-Saint-Jean
01 - RSS Bas-Saint-Laurent
08 - RSS l'Abitibi-Témiscamingue
04 - RSS Mauricie et Centre-du-Québec
03 - RSS Québec
12 - RSS Chaudière-Appalaches
15 - RSS Laurentides
17 - RSS l'Outaouais
14 - RSS Lanaudière
05 - RSS l'Estrie
13 - RSS Laval
16 - RSS Montérégie
06 - RSS Montréal

parent families are below the low-income cut-off, the rate is higher for English-speaking single parent families at 36.5%. It is important to note that in the Montreal region, 41% of English-speaking single-parent families are low income, a rate that is higher than that in English-speaking communities in a majority of the administrative regions.

Quebec, in its 1998 social and health survey, has linked poor and very poor income levels to factors such as higher incidence of drug use, average to poor eating habits, food insecurity, a lack of recreational physical activity, excessive weight, long-term health problems, and high levels of psychological stress, among other impacts (ISQ, 2001). An understanding of how these factors are affecting the health status of English-speaking communities is an important aspect of identifying needs and determining the response of the health and social services system.

Another factor affecting socioeconomic status is employment. English-speaking minority communities in Quebec are second in Canada after the French-speaking minority in New Brunswick with respect to having unemployment rates greater than the surrounding majority communities. English-speaking communities experience an unemployment rate 17% higher than that of the Francophone majority. There are also important regional variations. In eight regions, English-speaking communities have an unemployment rate that is 30% or higher than that in French-speaking communities.

Social support networks contribute substantially to a community's vitality. 80% of English-speaking Quebecers turn to family and friends first in the case of illness as opposed to seeking the services of a public institution (10.7%). English-speaking communities lead all other official language minority communities in Canada with respect to the total of unpaid hours of assistance provided to seniors. This is striking in light of the shrinking caregiver generation in many English-speaking communities. The rate of unpaid care in nine administrative regions is 50% or greater in English-speaking communities than that of the Francophone majority communities.

These portraits provide important new information for planning authorities, public institutions and English-speaking communities involved in creating new access programs. Most importantly, this evidence base must be articulated in the new models of service organization emanating from the latest overhaul of the health and social services system.

3. Regional portraits of access to health and social services in English

The basis for provision of services to English-speaking people is a key factor in looking at the regional portraits of access to English-language health and social services. There is a distinction to be made between services in English provided on a voluntary basis, and entitled access to services. The entitled services are those services for which there is a legal institutional obligation to ensure they are accessible in English, taking into account the human, financial and material resources of the system. These services are identified in decrees (access programs) adopted by the Quebec government. Services provided on a voluntary basis carry no entitlement and can be accessible on an ad hoc basis. These may be services that are available if, by chance, a bilingual professional encounters an English-speaking person on a given day or shift, and "volunteers" to provide the service in English. There is no administrative or professional obligation to ensure these services are accessible on a continuous basis. There is generally a mix of these two types of services accessible in English in each region.

Assessing the 1999 access programs

The first portrait looks at the status of entitled services in each region as assessed by the Provincial Committee on the dispensing of health and social services in the English language

TABLE 1: RATING OF ACCESS TO ENTITLED SERVICES IN ENGLISH, BY SERVICE CATEGORY

Administrative Region	CLSC services, including Info-Santé	General and specialized medical services	Long-term care	Youth protection	Rehabilitation services (for all categories of clientele)
Bas-Saint-Laurent	4 (-)	2 (+)	4 (-)	4 (-)	4 (-)
Saguenay-Lac-Saint-Jean	4 (-)	4 (-)	4 (-)	1 (+)	4 (-)
Québec	1 (+)	2 (+)	1 (+)	1 (+)	4 (-)
Mauricie et Centre-du-Québec	4 (-)	4 (-)	4 (-)	4 (-)	4 (-)
Estrie	1 (+)	1 (+)	2 (+)	1 (+)	1 (+)
Montréal	2 (+)	1 (+)	1 (+)	1 (+)	1 (+)
Outaouais	1 (+)	1 (+)	1 (+)	1 (+)	2 (+)
Abitibi-Témiscamingue	2 (+)	1 (+)	4 (-)	1 (+)	3 (-)
Côte-Nord	2 (+)	3 (-)	3 (-)	1 (+)	3 (-)
Nord-du-Québec	2 (+)	3 (-)	4 (-)	3 (-)	3 (-)
Gaspésie-Îles-de-la-Madeleine	2 (+)	3 (-)	3 (-)	2 (+)	4 (-)
Chaudière-Appalaches	1 (+)	2 (+)	1 (+)	1 (+)	4 (-)
Laval	1 (+)	2 (+)	1 (+)	1 (+)	1 (+)
Lanaudière	3 (-)	3 (-)	2 (+)	3 (-)	3 (-)
Laurentides	1 (+)	3 (-)	3 (-)	1 (+)	3 (-)
Montérégie	1 (+)	1 (+)	1 (+)	1 (+)	1 (+)

Key:
Substantial access = 1 (+)
Moderately substantial but incomplete access = 2 (+)
Limited access = 3 (-)
Extremely limited or non-existent access = 4 (-)

(Provincial Committee, 1997, 1999). The Committee's evaluation identified gaps in services and priorities for improvement. A summary analysis of the Committee evaluations was undertaken in 2001 (Carter, 2001), and provides a rating of access to entitled services by service category and by region.

As seen in Table 1, the summary analyses identify four levels of access to entitled services for five categories of service. All sixteen of the 1999 access programs were reviewed and rated using the Provincial Committee's evaluation and recommendations for improving access.

Four regions had limited, extremely limited or non-existent access to entitled services provided by the range of primary level care delivered by the CLSCs. With respect to general and specialized medical services, seven regions had a negative access rating.

Eight regions were considered to be in deficit regarding guaranteed access to English-language long-term care programs; while four regions had limited, extremely limited or non-existent access to entitled services provided by youth protection centres. A highly vulnerable English-speaking clientele with serious psychological, physical or intellectual disabilities would have difficulty accessing rehabilitation programs in English in eleven regions.

Table 2 provides a portrait of entitled access to services in English according to the negative and positive ratings of entitled access to the five

TABLE 2: REGIONAL RATING OF ACCESS TO ENTITLED SERVICES IN ENGLISH

Regional rating	Administrative Region
Entitled access to an extremely limited, or limited range of services in English (-)	
	Bas-Saint-Laurent
	Saguenay-Lac-Saint-Jean
	Mauricie et Centre-du-Québec
	Côte-Nord
	Nord-du-Québec
	Gaspésie-Îles-de-la-Madeleine
	Lanaudière
	Laurentides
Entitled access to a moderate to substantial range of services in English (+)	
	Québec
	Estrie
	Montréal
	Outaouais
	Abitibi-Témiscamingue
	Chaudière-Appalaches
	Laval
	Montérégie

TABLE 3: LEVEL OF SATISFACTION WITH ACCESS TO SERVICES IN ENGLISH AN SERVICES PROVIDED IN ENGLISH, BY REGION AND CATEGORY OF SERVICE

Administrative Region	Satisfaction with access to services in English in their region		Doctor in a private office or clinic	CLSC (other than Info-Santé)	Info-Santé	Hospital Emergency or out-patient clinics	Overnight hospital stay	Ranking (all 5 service categories)
	Satisfied		Received services in English					
	%	Rank	%	%	%	%	%	Rank
*Bas-Saint-Laurent	38.5	11	66.0	11.8	31.6	3.2	11.3	15
*Saguenay-Lac-Saint-Jean	52.6	4	47.4	14.5	n/a	n/a	n/a	18
Québec	26.9	16	42.9	12.3	21.9	12.5	16.8	16
*Mauricie	12.2	19	2.9	4.1	n/a	n/a	n/a	19
Centre-du-Québec	39.5	9	35.6	23.0	16.8	19.4	16.7	17
Estrie	36.8	12	82.0	67.8	59.0	51.4	52.5	8
Montréal (east)	39.4	10	74.5	38.6	48.3	49.4	55.1	10
Montréal (centre	51.0	5	93.7	72.0	68.6	79.0	80.9	3
Montréal (west)	55.3	3	97.9	80.5	81.5	85.9	93.6	1
Outaouais	42.9	7	93.2	84.9	92.4	84.2	75.7	2
*Abitibi-Témiscamingue	69.0	1	78.6	75.6	56.1	84.5	65.1	4
Côte-Nord	49.0	6	77.7	71.9	57.4	64.1	76.3	7
*Nord-du-Québec	67.3	2	66.5	97.0	56.0	74.4	76.1	6
Gaspésie-Îles-de-la-Madeleine	35.4	13	84.9	67.6	88.2	48.7	39.8	9
Chaudière-Appalaches	25.8	17	59.7	34.7	n/a	19.8	39.8	14
Laval	34.4	14	73.1	50.4	47.0	49.2	53.3	12
Lanaudière	20.8	18	60.0	36.5	21.1	46.5	33.8	13
Laurentides	32.5	15	65.3	39.1	36.1	55.7	64.7	11
Montérégie	40.1	8	82.3	71.5	62.5	65.9	74.5	5
TOTAL	45.9	n/a	86.2	66.7	63.0	70.3	74.1	n/a

* Due to a small sample size, data for the indicated regions should be used with caution

categories of service identified in Table 1 (Carter, 2001).

Community perceptions of access

The next portrait looks at the most recent survey of the perceptions and expectations of English-speaking Quebecers with respect to access to English-language services. In 2005, the CHSSN commissioned CROP polling firm to survey over 3,000 English-speaking persons across Quebec on a range of issues related to community vitality. As seen in Table 3, the survey results related to health and social services reveal significant regional differences in the level of access to English-language services (Pocock, 2006). These would include both the entitled services as well as those offered in English on a voluntary basis.

Rating satisfaction with access

Table 3 shows that the provincial rate of satisfaction with the general level of access to English-language services is less than 50% (columns 1 and 2). A closer look reveals significant differences between the regions. For example, in Montreal, while the rate of satisfaction was 55.3% in the western part of the Island, it was only 39.4% in the eastern part. Satisfaction levels comparable to or lower than 39% were evident in nine other regions. It must be noted that high levels of satisfaction were recorded for Abitibi-Témiscamingue and Nord-du-Québec. In both regions, the presence of First Nations or Inuit peoples, with certain services adapted to their linguistic and cultural needs, may account for this survey result.

What percentage received services in English?

The survey also provided information on the percentage of English-speaking respondents who received services in the different categories in English (Table 3: columns 3 to 8). Doctors in a private office or clinic were more likely than other professionals to provide their services in English. Access to CLSC, Info-Santé, hospital emergency and out-patient services, and overnight hospital care varied significantly among regions. In nine regions, less than 50% of English-speaking respondents received CLSC services in English. This was also the case in six to eight regions for Info-Santé and the different hospital services.

The bigger picture

A Health Canada study provides another dimension to the two portraits presented above. The study allows a comparison of the English-speaking minority with the French-speaking majority of Quebec, the French-speaking minorities outside of Quebec, and English-Canadians in the rest of Canada (ROC), with respect to their use of health services (Tipenko, 2006). Quebec's English-speaking minority scored the lowest of all the groups for questions related to having a regular doctor, use of hospital services and difficulty getting care from a specialist. The English-speaking minority also had lower ratings with respect to quality of health care, satisfaction with the health care provision, and quality of and satisfaction with community-based care.

Was the service offered in English, or did you have to ask?

The active offer of services in English by professionals in the health and social services system is an important indicator of the ability of the system to adapt to the needs of English-speaking communities. The CHSSN-CROP survey (Pocock, 2006) provides some indication of the extent of an active offer in different categories of service in Quebec. The active offer is defined as those services in English for which the user did not have to request the service in English, as the offer came from the service provider first. While there were significant variations between Quebec regions, doctors in private offices or clinics were the most inclined to provide an active offer of service in English (87%), while CLSCs demonstrated an active offer rate of 76%. Info-

Santé scored the lowest with 65% of its service response in English a result of an active offer to the user. Results also showed that approximately 80% of the hospital services provided in English to the survey respondents were the result of an active offer of English-language services.

With respect to English-speaking people requesting their services in English, a number of barriers can influence the results. These range from English-speakers who are too shy to ask, to those who feel their request would impose a burden on service providers or cause an undue service delay. The CHSSN-CROP survey also showed that the rate of discomfort when asking for services in English was the greatest (over 40% of respondents) in the regions of Bas-Saint-Laurent, Québec, and Chaudière-Appalaches. In six regions, over one-quarter of survey respondents were uncomfortable asking for services in English (Gaspésie-Îles-de-la-Madeleine, Centre-du-Québec, eastern Montreal, Laval, Lanaudière, and Mauricie). English-speaking respondents stated that the cause of discomfort was because they felt their request would impose a burden (25%), that a service delay would occur (22%); and 17% felt they were too shy to ask for services in English.

Promoting an active offer of services in English also requires that the public institutions inform communities of service availability. This also extends to health promotion and prevention campaigns. The CHSSN-CROP survey revealed that only 27% of respondents received information about services in English from public health and social services institutions. As well, only 21% received health promotion and prevention information from the public health system in English. As with other survey results, there were significant differences between regions with respect to receiving information in English.

4. Access programs and the new context of Quebec's health and social services system

The Quebec Liberal government recently embarked on a major reform to broaden the perspective of the health and social services system beyond a focus on service delivery to include improvement of health outcomes at the individual and population levels. In 2004, ninety-five health and social services centres (CSSS) were created by merging local community service centres (CLSC), long-term care centres (CHSLD) and, in most cases, a hospital. A second key reform was the creation of four integrated university health networks. These networks are assigned designated 'corridors', or territories, in order to facilitate access of the population of each of the territories to ultra-specialized services. In addition to structural changes, there are new orientations guiding Quebec's public health strategy which will support the development of public health plans at the provincial, regional and local levels.

One major objective of the reform is to remove 'silos' of professional practice and promote teamwork in the health and social services sector. Clinical and organizational plans are being developed that will significantly change the way in which health services will be offered to a regionally defined population (MSSS, 2004). The Quebec Ministry guidelines for development of the new access programs of services in English identify orientations for determining the means by which English-speaking people will gain access to the services they need in the reformed system (MSSS, 2006). These orientations are identified in the next section along with challenges that English-speaking communities and service providers will encounter trying to implement them.

Population-based responsibility: the issue of "taking charge"

Service providers who offer services to the population of each of the ninety-five territories have a common responsibility to ensure access to a

wide range of services. This model promotes a system responsibility to "take charge" of the person and provide support while that person is engaged with the Quebec health and social services system. The greatest risk for the future of services for English-speaking communities lies in the complexity of the multi-year service reorganization process. The full implementation of the ninety-five local services networks still lies ahead. A number of means to improve access to services, that are likely to be identified in the access programs, have been deemed to be successful in the short term. The challenge will be to sustain these improvements over the long haul in order that they form an integral part of the new network structure.

Hierarchical organization of services: the issue of inter-territorial access

The introduction of the service corridors aims to address the issue of timely access to specialized and super-specialized medical services. The challenge lies in the territorial configuration of the four integrated university health networks and the potential change in the historical mandates of the English-language teaching hospitals of the McGill University health network. Three Francophone university health networks are now responsible for ensuring that the minority English-speaking communities in their 'corridors' have access to tiered medical services. Correspondingly, the McGill network must ensure capability of serving Francophone populations in Abitibi-Témiscamingue, Outaouais, and parts of the Montérégie region. While the patient's "freedom to choose" the institution for service is acknowledged, it is clear that each of the four university health networks will have to concentrate efforts on organizing services to meet the needs of the populations within their assigned zones.

For the Montreal region, there is a particular dynamic created by the presence of the McGill and Université de Montréal networks. The McGill corridor is limited to part of the central section of Montreal, along with the western sector of the island of Montreal. A question will eventually arise with respect to access for English-speaking communities in the eastern and northern parts of the Montreal region. Will English-speakers in these Francophone majority areas of the island have access to the McGill hospital network, given its official bilingual status? Unless agreements are reached between the Université de Montréal and the McGill networks allowing inter-corridor access, English-speakers living in the Université de Montréal corridor will have to seek their specialized services from the Francophone hospital network. The issue will become more acute, as the respective university health networks eventually reorganize their resources to meet "populational responsibilities" in their assigned corridors.

Mobility of persons within the network: the issue of navigation

The Quebec Ministry orientation prescribes that it is not up to the English-speaking user to navigate the system, but rather that the system should "welcome him, ascertain his needs with him, recommend the most appropriate response, and guide him toward an effective service." These functions are conventionally grouped in an intervention program at the first point of contact of the user with the system.

One of the key indicators of improved access to services in the new access programs will be the number of health and social services centres (CSSS) that have accepted the obligation to provide their first contact program in English. While comparisons with the 1999 access programs are difficult, there appears to be a demonstrated willingness of the majority of CSSS to extend their "populational responsibility", at least at the first contact level, to their English-speaking communities (Provincial Committee, 2007).

Success of clinical interventions: the issue of language and communication

This Ministry orientation recognizes that in the health and social services field, providing services in the language of choice of the user is essential for successful clinical intervention. The statement is, in effect, an acknowledgement that language barriers can have an adverse effect on access to health and social services. Studies have confirmed that language obstacles to communication can reduce recourse to preventative services; increase consultation time including the number of tests; lead to the possibility of diagnostic or treatment errors; affect the quality of specific services highly dependent on effective communication; reduce the probability of treatment compliance; and reduce users' satisfaction with the services received (FCFA, 2001).

While the affirmation of the importance of language in clinical intervention is an important orientation, the "tailoring of an adapted and personalized response" to the needs of English-speaking people faces formidable challenges in Quebec. These include a shortage of human resources capable of providing services in English; lack of a sufficient volume of service requests in English; difficulty in planning services due to a lack of information on needs and use of services; ambiguity concerning the legal framework governing the language of work (French) and the legislative guarantees of services in English; and low capacity of a number of communities to engage the public system to respond to needs (CCESMC, 2007b).

Participation of English-speaking communities: the issue of capacity

The Quebec Ministry orientations for new access programs encourage participation of English-speaking communities at the institutional level, in order to ensure that needs are taken into account in the planning and delivery of services. This is important, given the evidence of under-use of public services by English-speakers; under-representation of English-speaking Quebecers in the personnel of the public system; and the challenges for communities to participate in institutional governance structures (CCESMC, 2007b).

5. Building foundations: Results of the 2003 federal Action Plan in Quebec

Mobilization of English-speaking communities has had a major impact on recent federal policy initiatives aimed at expanding the means available to communities and the Quebec system to improve access to English-language services. Concerted action of a network of community organizations, public institutions and other stakeholders led to an evidence-based strategy to shape federal action and win the support of the Quebec government, the health and social services system and the Francophone majority. In July 2002, a newly-created consultative committee of community and Health Canada representatives co-signed a report to the federal Minister of Health proposing a multi-year plan to improve access to health and social services in English. The recommendations served as a guide for the federal Action Plan for Official Languages launched in March 2003. The Plan supported three levers proposed by the consultative committee: community-institutional networking; adaptation of service delivery models (primary health care); and training and human resources development (CCESMC, 2002).

The investments have supported activities that are closely linked to the structural reforms in Quebec's health and social services system that will affect the whole population including English-speaking minority communities. Formative and final evaluations of the activities are indicating that the investments are beginning to bear fruit. Successful implementation of the measures and positive assessments of early results strengthened the resolve of stakeholders to sustain results and set the stage for long-term changes that aim to

improve health outcomes for Quebec's English-speaking communities. Table 4 presents a summary of the results of the federal Action Plan.

Networking and partnership initiative

Eleven formal networks are bringing together English-speaking minority communities and service providers at the local, regional and provincial levels. Most of these networks are working to integrate the other two measures funded under the Action Plan. The approach is ensuring that community participants in each network have a vital minimum capacity to mobilize and create networks with public partners. The institutional stakeholders are gradually making formal commitments to participate and contribute to the achievement of shared objectives.

Primary Health Care Transition

The Community Health and Social Services Network (CHSSN) implemented thirty-seven primary health care transition projects in a fifteen-month period ending in March 2006. Projects were carried out in fourteen administrative regions with the aim to improve access to primary level health and social services in English and foster links between English-speaking minority communities and service providers. Three priority areas were targeted: better access to health information lines (Info-Santé); improved access to front-line community-based health and social services; and adaptation of living environments in institutions to meet cultural and linguistic needs of English-speaking people. An additional twenty-three primary health care transition projects were

TABLE 4: 2003 – 2008 FEDERAL ACTION PLAN
MEASURES TO IMPROVE ACCESS TO SERVICES FOR ENGLISH-SPEAKING COMMUNITIES

Measure	Action Plan investment	Activities and Results
Networking and Partnership Initiative (QCGN)	$ 4.7 M	-9 regional and local partnership networks • 26 CSSS territories -1 sector network (drug and alcohol addiction) • Prevention networks in the eastern Quebec regions -1 provincial network (CHSSN) • 64 member organizations • Community Support Program (implementation of the Networking and Partnership Initiative • Partnership with the Quebec Ministry of Health and Social Services (implementation of 60 primary health care transition projects) • Partnership with the McGill Training and Human Resources Development Project (community liaison and Telehealth)
Primary Health Care Transition (CHSSN)	$ 13.4 M	-37 projects 2004-2006 -23 projects 2006-2007 • Improvement in provision of the Info-Santé program; access to primary level care; and adaptation of long-term care programs • Improved links between communities and service providers
Training and Human Resources Development (McGill University)	$ 12 M	-Language training of Francophone professionals • 1,427 Francophone professionals in 81 institutions in 15 regions (2005-2006) -Retention of professionals in the regions • 22 pilot internship projects in 14 regions with 132 confirmed offers of internship (2007-2008) -Distance community support (contract with CHSSN) • Health promotion by videoconferencing in 11 isolated communities, 28 videoconferencing sites, reaching 700 English-speaking participants -Distance professional support • Pilot measure offering programs supporting English and French-language professionals serving isolated or distant English-speaking communities
Total	$ 30.1 M	

funded for 2006-2007. The projects were built on the first phase of the primary health projects by adding resources to develop models to better track English-speaking clientele; adapt services as part of developing clinical and organizational projects; and strengthen partnerships between institutional and community partners. Service providers and community organizations surveyed on project results have affirmed that conditions of access in participating institutions have generally improved. This has occurred through an increase in personnel capable of providing service in English; adaptation of services to better respond to needs; and an increased knowledge of the community. As well, English-speaking people are becoming more informed of services as a result of strengthened ties between community organizations and service providers.

Training and human resources development

The McGill University Training and Human Resources Development Project is contributing to an enhanced capability of the Quebec health and social services system to ensure its human resources can provide continuous quality services to English-speaking people. A key feature is an innovative partnership model involving the seventeen regional health and social services agencies, health and social services institutions, language training organizations and community organizations. The impact of the project is apparent when looking at the reach of activities and nature of results described in Table 4.

The engagement of McGill is part of a community strategy to ensure its historical institutions are engaged, or re-engaging, with communities in efforts to improve access to services. McGill is the only English-language institution offering a complete range of professional degree programs in the health and social services fields. Its unique position is creating a new role for the English-language educational milieu in training and supporting professionals who work, or intend to work, in the regions. Its leadership in research is adding to the potential to create new knowledge in a number of areas of interest to communities and service providers.

Sustaining results

In gauging the future of health and social services in English, it is clear that investments are required to provide a reasonable capacity for Quebec's health and social services system and English-speaking communities to improve access to English-language services. This is commonly referred to as "oxygen" in a system starved for resources and "capacity" for communities to ensure they play a meaningful role. There is clearly an answer to any potential questioning of the federal government's investments "for Quebec Anglophones while there are Francophones who have problems of access". English-speaking representatives determined that about 85% of the $30.1 M investment should go into Quebec's health and social services system to provide means for Francophone professionals and their institutions to better serve an English-speaking clientele. The Quebec health and social services system as a whole is clearly a beneficiary of this "oxygen" and has returned the gesture with what feels like a genuine commitment to include English-speaking communities in the vast reforms currently underway. This result has expanded the range of stakeholders in the implementation of the federal Action Plan and any new initiatives planned for the future. This new dynamic is probably the most important one in promising sustainability of results of current efforts and securing the future of English-language health and social services in Quebec.

6. What future for English-language health and social services: a blueprint for action

It is fitting to conclude with a look at the new community blueprint to shape the future of health and social services in English in Quebec. The four linked strategies aim to guide collective efforts to maximize benefits of current initiatives and set the stage for future action. They are contained in a new report to the federal Minister of Health submitted by the Health Canada Consultative Committee (CCESMC, 2007b). As with all blueprints, the proof is in the building, and creating the conditions for success will continue to require the determination and mobilization of Quebec's English-speaking communities.

A. Consolidating new networks of communities and public partners

Formal networks of communities and public partners are seen as a key to sustaining results of current investments and promoting the longer-term changes needed to improve health outcomes in English-speaking communities. A strategy of creating durable partnerships between communities and the broader health and social services system is also seen as a way to reinforce links between English-speaking communities, their resources and their historical institutions. The network model has been effective in facilitating the integration of measures into communities and the health and social services system. The networks have mobilized a range of stakeholders, including community organizations and public institutions, around the common purpose of promoting projects and partnerships to improve access to services in English. The Quebec Ministry of Health and Social Services has become an important collaborator in accepting the community-led initiatives to bring federal resources into the health and social services system. This relationship will be key to joint development of a framework to guide integration of future federal investments. A new federal commitment is recommended to continue support for the existing eleven partnership networks; as well as provide new resources to develop networks in another twenty-four territories touching an additional 30% of the English-speaking population in vulnerable communities.

B. Strategic entry points for action to improve health outcomes

A second strategy identifies key entry points for new federal investments aimed at promoting new models of service organization to improve health outcomes for English-speaking communities. The strategy addresses the limitations of short-term projects to improve access, and looks toward investments incorporating a more long-term structural approach to change. The goal is to secure quality services for English-speaking communities as a more permanent feature of Quebec's health and social services system.

One aspect of this strategy considers the transfer agreements between the federal government and Quebec for health funding, and proposes earmarking portions of the transfer for development of new models of service delivery for English-speaking communities. This is one way to ensure federal contributions are consistent with Quebec's priorities for improving health outcomes and adapting its service system. It aligns with possible changes in federal transfer policy that may effect how the federal government promotes the vitality of official language minority communities. To address the issue of the human resource capability of the Quebec system to serve in English, the Consultative Committee is proposing that a multi-year federal contribution support language training of French-speaking professionals. It is projected that over 4,000 Francophones will have benefited from the first commitment. However, ongoing reorganization of personnel and turnover due to retirement require recurrent resources. As well, French language training for English-speaking graduates of professional degree programs is seen as one way to keep graduates in Quebec who are more comfortable working in a Francophone

milieu. Continued funding is recommended for partnerships that bring French-language institutions, English-language professional degree programs and English-speaking communities together to promote internships and eventual employment in the regions.

Community representatives have mapped out new investments to promote technology to better serve English-speaking communities. This stems from a very successful initiative using Telehealth (videoconferencing and community radio) to extend health promotion services to isolated communities. Once again, the strategy looks at earmarking budget envelopes for English-speaking communities within major infrastructure programs such as Canada Health Infoway and the Canadian Foundation for Innovation. These are the programs most likely to contribute to the development of Quebec's telecommunications network.

A federal contribution is proposed to encourage communities to participate in Quebec's Public Health Plan, which will foster new public health initiatives at the provincial, regional and local levels. The investment will also support community participation in a new national Public Health strategy. As part of its multi-sector approach, the Committee is promoting federal interdepartmental partnerships with English-speaking communities to support introduction of health promotion programs into the new Community Learning Centres, a community development project in the education sector supported by the federal Action Plan.

C. Informing public policy and influencing public opinion

Informed public policy and effective government action is essential if real progress is to be made with respect to ensuring the vitality of English-speaking communities. The community blueprint for action acknowledges that the government and its agencies are important stakeholders in the implementation of strategies to improve access to services for English-speaking communities. Demonstrating the impact of investments meets accountability requirements, but it also provides an important lever for communities to shape public policy. Effective evaluation of results of projects and partnerships encourages knowledge transfer among organizations; supports coordinated strategies; and influences policy makers, planners and politicians at both levels of government.

Effective community participation in advisory bodies at the provincial and federal levels has played an important role in shaping policy and government actions that benefit English-speaking communities. Community representatives have coordinated their advice to the two levels of government so that federal investments in Quebec are accepted by the provincial government as measures supporting Quebec's initiatives to improve access to English-language services (legislative guarantees). Correspondingly, the federal government is assured that proposals emanating from representatives of English-speaking communities have the support of Quebec. In that regard, the provincial advisory body has assessed the federal investments and recommended to the Quebec Minister of Health and Social Services that he and his government support future Health Canada contributions.

Another important aspect of this strategy is the integration of the results of the federal Action Plan into the new access programs. Several of the regional access programs are identifying the Action Plan measures as means to implement the new programs. A number of the programs used new health determinant and demographic portraits of English-speaking communities to identify needs. These portraits were generated by the community-based partnership networks.

D. Strategic knowledge development

The fourth linked strategy sees strategic knowledge development as a means for mobilizing all stakeholders working to improve access to

English-language services. One aspect promotes knowledge development and dissemination, while the other proposes research partnerships in the university, institutional and community milieus. The strategy has already produced reliable and detailed data on English-speaking communities being used by a host of organizations. More challenging is the development of inter-university research programs, community-university research alliances and other partnerships bringing communities together with the research and university communities. In this regard the community representatives are proposing a federal action plan with dedicated funding for research on official language minority communities.

Conclusion

It is clear that the anchor for English-language services remains the legislative framework reflecting the fundamental importance of language and communication in the provision of human services. The legislative provisions that guarantee the right to services in English, within system limits, also guide the multitude of players that comprise the health and social services system. Experience has taught community leaders that when the integrity of the legislation is maintained, progress is made. When that integrity is questioned for whatever reasons, it is not only a threat to English-language services, but to the future of English-speaking communities as well. Communities must be "fire hall ready" to respond to any new political scenarios that may stimulate old debates about the legitimacy of legislative guarantees. It is also clear that sustaining progress and meeting new challenges will continue to require cooperation between the provincial and federal levels of government, with formal recognition of English-speaking communities as full partners. In this manner, federal policy and resulting measures supporting Quebec's initiatives will reflect the interests of all stakeholders, reinforce current public investments and ensure the long-term commitment of government to the vitality of English-speaking communities.

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The Author

JAMES CARTER is the program and policy advisor to the Community Health and Social Services Network (CHSSN). He has been one of the community architects of the measures improving access to health and social services in English supported by federal Action Plan for Official Languages. He is a member of government-appointed committees advising the Quebec government and the federal Minister of Health on access to health and social services in English. He was the secretary of the provincial advisory committee during the 1990s, and was a political advisor to ministers in the Liberal government of Robert Bourassa prior to this appointment. In the 1980s, he was a policy advisor to Montreal's major English-language social services institution (now Batshaw Youth Centres), after many years of community organizing in the Montreal region. Contact: chssn@sympatico.ca.