

**BEYOND THE SERVICE
PARADIGM: THE IMPACT
AND IMPLICATIONS OF
CONSUMER/SURVIVOR
INITIATIVES**

JOHN TRAINOR,
MARNIE SHEPHERD,
KATHERINE M. BOYDELL,
ALLYSON LEFF &
ELAINE CRAWFORD

JOHN TRAINOR, MSW, IS THE PROGRAM MANAGER OF THE COMMUNITY SUPPORT AND RESEARCH UNIT, QUEEN STREET MENTAL HEALTH CENTRE, IN TORONTO, AND A LECTURER AT THE DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF TORONTO, CANADA.

MARNIE SHEPHERD, BA, IS THE COORDINATOR OF THE CONSUMER/SURVIVOR DEVELOPMENT INITIATIVE, ONTARIO.

KATHERINE M. BOYDELL, MHSC, PH.D. IS A RESEARCH SCIENTIST AT THE COMMUNITY SUPPORT AND RESEARCH UNIT, TORONTO AND AN ASSISTANT PROFESSOR IN THE DEPARTMENT OF PSYCHIATRY AT THE UNIVERSITY OF TORONTO.

ALLYSON LEFF, IS THE ADMINISTRATION AND FINANCE ASSOCIATE AT THE CONSUMER/SURVIVOR DEVELOPMENT INITIATIVE, TORONTO.

ELAINE CRAWFORD, BSC, IS A RESEARCH ASSOCIATE AT THE COMMUNITY SUPPORT AND RESEARCH UNIT, QUEEN STREET MENTAL HEALTH CENTRE, TORONTO.

FOR FURTHER INFORMATION CONTACT JOHN TRAINOR, AT QUEEN STREET MENTAL HEALTH CENTRE, 1001 QUEEN STREET WEST, TORONTO, ONTARIO, CANADA M6J 1H4.

The purpose of this paper is to examine three key aspects of consumer/survivor controlled organizations: the range of activities carried out by these groups; the impact of involvement as reported by participants, and the relative importance consumer/survivors attach to these organizations as components of the mental health system. The implications of these findings for mental health policy will also be examined.

Consumer/survivor organizations are defined as being operated for, and controlled and staffed by, people who have used the mental health system. The data for this study are taken from the Consumer/Survivor Development Initiative, a program in Ontario, Canada, which, at the time of study, directly funded 36 organizations.

INTRODUCTION

The period of deinstitutionalization has witnessed a steadily evolving notion of the skills and capacities of people with mental illness. Initially, in the 1960s, there was little change in approach from the institutional era. The early phases of this process were characterized in part by the transfer to the community of institutional strategies and practices. Referred to in the United States as "transinstitutionalization" and in Canada as the emergence of "new

back wards," many consumer/survivors of mental health services were denied the opportunity to participate in community life (Murphy, Pennee & Luchins, 1972; Talbott, 1979).

In response to this and other aspects of deinstitutionalization, a wide range of innovations has emerged in the area of community support (Anthony & Blanch, 1989; Bachrach, 1981). Broadly speaking, these can be grouped into two closely related areas: attempts to improve elements of basic social support such as housing and income, and

new approaches to providing mental health services (of which the various components of psychosocial rehabilitation are the most prominent) (Kaufmann, 1995; Wollert, 1986). Perhaps the most striking feature of these new service models is their recognition of the capacities of individual consumer/survivors (Carling, 1993; Chamberlin, Rogers & Ellison, 1996; Macnaughton, 1992; Rapp, Shera & Kisthardt, 1993; Segal, Silverman & Temkin, 1993; Shelton & Rissmeyer, 1989). The approach to service provision in these models focuses on exploring an individual's abilities as they relate to dealing with a particular illness and to living and working in the community. Ideally, the support offered by staff members contributes to recovery, a complex process through which consumer/survivors gain mastery over their illness (Anthony, 1993; Deegan, 1988; Noh & Turner, 1987; Spaniol & Koehler, 1994; Spaniol, Koehler & Hutchinson, 1994).

In addition to there being developments in the service system, state and provincial governments in the United States and Canada are showing interest in a new strategy which recognizes the capacities of consumer/survivors. The emphasis in this approach is to provide resources directly to organizations of consumer/survivors for advocacy, community economic development, and self-help, independent of professional staff or agencies (McLean, 1995; Mowbray, Chamberlin, Jennings & Reed, 1988; Rapp et al, 1993; Segal et al, 1993; Segal, Silverman & Temkin, 1995; Shelton & Rissmeyer, 1989). In the United States a review by the Human Resource Association of the Northeast found increasing activity in this area, with a majority of states indicating that funding would be increased in coming years (Specht, 1988). In Canada, a similar increase in activity has been found, both at the policy

and funding levels of government (Macnaughton 1992; Trainor, Pomeroy & Pape, 1993; Trainor & Tremblay, 1992).

Although systematic interest by government in the potential of consumer/survivor organizations is relatively recent, the phenomenon of consumer/survivors taking action on their own behalf is not. Two historical roots can be traced in the development of consumer/survivor groups today. The ex-patients' movement, described by Chamberlin (1990), can be traced back to the late 1960s and early 1970s, with historical aspects that go back much farther. Many of the early groups in this movement were advocacy oriented and sharply critical of mental health and psychiatric practice (Chamberlin 1990; McLean, 1995; Shelton & Rissmeyer, 1989). The other historical root that contributes to the current situation is the self-help movement reflected in such groups as Recovery Incorporated and Grow, which date from the 1930s and 1950s respectively (Galantei, 1988; Lee, 1995; Omark, 1979; Powell, 1975). According to Zimmerman and his colleagues (1991), the main goal of these self-help organizations is to integrate members back into the community without interfering with the mental health system or threatening the role of professionals.

The rich base of consumer/survivor organizations and the increasing awareness by government of the potential role that they can play in community support have led to increased funding and recognition. In 1991, the Ontario Ministry of Health began the systematic funding of groups such as these under a program called the Consumer/Survivor Development Initiative (CSDI). Prior to 1991, small amounts of funding had been provided, albeit in a haphazard manner. The 1991 initiative committed 3.1 million dollars to these groups and

provided additional funds for a central support and monitoring team. Funding was raised to 3.5 million in 1992 and remained at that level at the time of writing. The initial program grants went to a mix of fully independent consumer/survivor organizations and developmental projects sponsored by existing mental health agencies. The policy focus that guided the funding was clarified during the first year to restrict eligibility to consumer/survivor controlled organizations, and by the end of the second year all of the groups were either fully independent or well on the way.

Thirty six CSDI projects are currently in receipt of funds, with the average annual budget being \$97,222, with a range from \$22,000 to \$225,000. The breakdown of the groups is as follows: 6 are cooperative businesses (such as a courier service, commercial cleaning, and food preparation); 1 is a provincial business council, which provides support to the six businesses and to new ones; and 28 groups are generic consumer/survivor organizations, which typically have a local or regional mandate to organize consumer/survivors and develop a series of activities and initiatives that reflect their interests. The final organization is diagnostically focused (the Mood Disorders Association of Ontario) and is unique in having both consumer/survivor and family members. All of the organizations are required to be democratically operated, independent, and, with the exception of the mixed group noted above, to be consumer/survivor controlled. The average membership is 90.

The funding criteria of Ontario's Consumer/Survivor Development Initiative allowed for a wide range of activities including advocacy. However, an examination of the types of activities that emerged must be seen in the light of the one major restriction that the

funding did impose. This restriction related to the provision of direct services; CSDI groups were not supported in developing traditional service models that featured clients and providers (even if the providers were consumer/survivors). This restriction stemmed from the mandate of the Ontario Initiative. The goals of the funding were twofold; they were intended to respond to calls by consumer/survivors for both a base of organizations that they controlled, and for the chance to deal in a new way with the mental health issues that they faced.

This new approach was centered on the skills and knowledge that people have to help themselves and each other, and emphasized the collective capacities of consumer/survivors. These factors were seen as incompatible with what has been referred to in other Canadian studies as the service paradigm (Trainor et al., 1993; Trainor & Tremblay, 1992). The service paradigm assumes that the only model of action in helping people with mental health problems is to make them clients and provide services. This paradigm is so dominant in mental health policy as to be almost invisible. In fact, there are quite different models of action based on the principles of mutual aid and self-help, and it is these non-service alternatives that the CSDI funding sought to explore. (Kaufmann, 1995; Mowbray et al., 1988; Rappaport, 1985). The following examples, condensed from the core CSDI policy document, illustrate the distinction between an organization developing services and one utilizing non-service alternatives:

- Consumer/survivors in a particular organization identify the need for support during times of crisis. A response based on the service paradigm might feature an initiative by agency staff members to start a crisis support service. Members can call

and receive help as clients. In contrast, a non-service approach tackles the problem differently. Members who are interested in the problem of crisis support might meet and define the issues that are important to them. They explore ways to help each other during times of crisis, discussing options such as forming a self-help group, exchanging phone numbers, or meeting one-to-one. Staff act as facilitators of the process, not service providers. Members recognize that their personal experiences with crises give them a head start when it comes to helping others.

- Consumer/survivors identify the need for employment in a supportive environment. In the service paradigm, staff members usually start and run a vocational rehabilitation service in which people are treated more as clients than employees. In the consumer/survivor model, people meet as equals and decide to start a business venture. They may seek out those with proven business expertise for advice and possible inclusion on a board or committee. Anyone who performs day-to-day management functions is accountable to the members. No one is treated as a client or a case. Everyone is a co-worker and employee. All people work together to make their business succeed in a competitive marketplace. Everyone has a say in how the organization is run.

The policy restriction that prevented CSDI groups from operating services was based on the desire to use the limited dollars available to explore the potential of new models. It was not based on any assumption that consumer/survivors should be excluded from playing a role in service delivery. In fact, the mental health policy adopted in

Ontario in 1993 specifically supports a positive role for consumer/survivors as service providers (Ontario Ministry of Health, 1993). The purpose of this paper is to examine four aspects of consumer/survivor controlled organizations: the range of activities carried out by these groups; the impact of involvement as reported by participants; the importance consumer/survivors attach to these organizations as components of the mental health system; and implications for mental health policy.

METHODS

Several sources of information were used to examine the operation and impact of CSDI organizations. Staff members of the central support and monitoring team at CSDI were in close contact with funded organizations and conducted detailed annual reviews. In addition to this, two evaluation studies were carried out. The first focused on the impact of membership in a CSDI group on the use of mental health services. It involved a sample of 14 funded organizations as chosen by the central team. To make the sample as representative as possible, team members selected projects that reflected the size, rural/urban mix, and type of all the organizations. Each organization was provided with questionnaires that itemized various types of mental health services. Because some of the organizations reported making extra copies of the questionnaire, it is not possible to determine the exact number distributed, but 194 questionnaires were returned. Respondents listed the various mental health services that they used for an equivalent period of time before and after becoming members. The recall bias inherent in such a method might act against finding that membership in a CSDI group would decrease service use. In fact, a very robust finding did occur and is reported below.

The second study was larger in scale and examined a wide range of issues, including the impact of membership in a CSDI group and the relative importance consumer/survivors attach to various components of the mental health system. The methods and implementation process of the second study were designed and monitored by a committee composed of 10 consumer/survivors and 2 consultants who were not consumer/survivors. The consumer/survivors involved were from CSDI groups as well as the central support and monitoring team. A questionnaire was developed and pre-tested. Responses were then obtained as follows: 1) questionnaires were sent to all active members (defined as people who had regular contact with the group, at a minimum once every two months) as well as a random sample of 20% of less active members of 33 of the 36 organizations. A total of 439 responses were received from the 1883 questionnaires sent out; 2) a modified version was sent to one of the organizations, the Mood Disorders Association of Ontario, wherein funding goes to a provincial umbrella group comprised of over 30 branches. Seventy-four responses were obtained from a convenience sample of various branches. The questionnaire was modified to reflect the fact that this organization's branches do not receive funds directly and also include family members. Only consumer/survivor responses were used for this study; 3) focus groups were held with a convenience sample of 16 organizations and 140 participants in these groups volunteered to fill out shortened versions of the questionnaire; 4) two groups did not participate, one due to organizational difficulties, and the other (the provincial business council) because its membership is composed of organizations, not individuals. The total number of questionnaires returned was 653. There were no significant

differences between the various groups of respondents on ratings of impact of involvement and perceptions of helpfulness or harmfulness. Consequently, results are reported in aggregate.

RESULTS

Activities Carried Out by Consumer/Survivor Organizations

From 1991 to 1994, the activities of the 36 consumer/survivor organizations were monitored. The monitoring process was carried out by the central team. On average, programs were visited four times per year. On one of these visits a detailed review was carried out. Staff members, representatives of the board, and a sample of members were interviewed with the following areas of focus; governance and structure, management and administration, and programs and goals. By the end of the period it was found that seven basic areas of activity had emerged. These are listed in rank order with the percentage of organizations involved in each area.

1. Mutual support (93%): Developing and maintaining self-help groups and offering peer support.
2. Cultural activities (83%): Pursuing a range of artistic and cultural activities. These ranged from poetry in newsletters to workshops and other events designed to share completed work and build new skills.
3. Advocacy (80%): Advocating for better mental health and related social services. CSDI groups were active in many areas including local mental health services and planning groups. They also participated in provincial level policy development.
4. Knowledge development and skills training (80%): Creating and distributing resources based on the knowledge of consumer/survivors

and providing opportunities for individual members to learn from each other and enhance their own skills. Consumer/survivor groups produced written material and videos, which were circulated to other organizations.

5. Public education (73%): Providing education, sensitization, and training to the public. This included working with local media to present an accurate picture of the lives of consumer/survivors and participating in community events and forums as guest speakers and resource people.
6. Educating professionals (70%): Providing education, sensitization, and training to mental health professionals. This involved teaching classes, hosting field placements, and acting as faculty. Work was also done with professional associations and service providers.
7. Economic development (37%): Developing and operating small community-based businesses. These businesses are consumer/survivor run and controlled. They include restaurants, commercial cleaning, and courier services. These activities were the main focus of six groups, while others carried out smaller projects.

Perhaps the most critical finding of this emerging list of activities is the wide range of issues that was tackled by the CSDI funded groups. The skills and knowledge of consumer/survivors, using models of action that emphasize their collective capacity to help each other (rather than using service models), proved capable of addressing a wide range of issues.

Table 1—Use of Mental Health Services Before and After Joining a CSDI Project (N = 194)

SERVICE	BEFORE CSDI	AFTER CSDI	<i>p</i>
Mean Number of Inpatient Days	48.36	4.29	.001
Mean Mean Number of Outpatient Visits	22.00	16.80	.001
Mean Number of Physician Visits	13.40	9.59	.01
Mean Number of Crisis Contacts	3.54	.81	.001

Table 2—Impact of Involvement in a CSDI Group

CATEGORY	MEAN	NUMBER
Involvement in Community	7.8 (SD 2.19)	597
Contact with Others	8.2 (SD 1.78)	593
Self-Confidence	8.1 (SD 1.90)	596
Having Choices	7.8 (SD 1.99)	586
Being in Control	7.8 (SD 1.98)	592
Day-to-Day Coping	7.8 (SD 1.97)	592

Mean scores are based on a scale of 1–10, with 1 having the most negative impact and 10 having the most positive impact.

Key Impacts of Involvement in Consumer/Survivor Initiatives

To put the results of the impact of involvement in context, we must first look at who uses the CSDI organizations. This is a difficult question to answer in the context of research with consumer/survivor groups. The style and character of these groups is not conducive to research that probes individual psychiatric histories or diagnoses. Despite this, consumer/survivors were willing to share their experience in using mental health services. In the context of the Ontario system, general conclusions can be drawn from the types of services used. In particular, provincial hospitals (the equivalent of state hospitals in the U.S.) are used primarily by people with serious mental illness. Using this indicator, we can conclude that the majority of group members have dealt with serious mental health problems. Ninety-two percent of respondents reported on their experience in provincial psychiatric hospitals.

In addition, 74% reported on inpatient experience with general hospital psychiatric units. These figures coincide with the impressions of the staff of the central team, which visited the programs several times a year.

Use of mental health services.

Respondents in the first study described in the methods section above were asked to report on changes in their use of specific types of mental health services after being involved in a CSDI group. They were asked to document inpatient days, hospital admissions, crisis contacts, outpatient visits, and private physician visits for the time they had been involved in CSDI and for an equivalent amount of time before their involvement. For comparative purposes, all figures were then standardized to one year before and one year after joining a CSDI group.

One-way analysis of variance (paired comparison *t*-test) was used to test for pre-post differences in use of mental

health services. Results of this study indicate that service use in all categories drops after joining a CSDI group. The most significant declines in usage are found in inpatient bed use ($p = .0001$), as measured in days, and crisis services ($p = .0008$). The inpatient figure is particularly dramatic, representing a drop in the annualized inpatient days from 48.36 to 4.29. Admissions to hospitals for psychiatric reasons also dropped from a mean of 2.7 admissions to a mean of .64 admissions. Outpatient visits were also significantly reduced ($p = .009$) as were private physician visits ($p = .04$), although not to the same extent as the previous two categories. These results are summarized in Table 1.

The pattern of these service-use reductions suggests that membership in a group helps consumer/survivors either avoid, or handle in a new way, the most difficult kinds of situations, those requiring crisis services or inpatient admission. At the same time, there are less dramatic reductions in “maintenance” services such as outpatient visits.

Impact of involvement on other areas.

As indicated in Table 2, there were several additional areas of impact. The first two areas were involvement in the community and contact with other individuals. It has been argued that involvement in organizations exclusive to consumer/survivors simply contributes to ghettoization. In fact, results indicate that involvement acted as a mediating influence for wider involvement in the community. Respondents reported increased contacts with other people (both consumer/survivors and non-consumer/survivors) as a result of being members of a CSDI organization. More than 60% of respondents stated that contacts with non-consumer/survivors had increased as a result of their CSDI involvement. Comments made in the focus groups also confirmed that involvement was helpful in developing

broader contacts in the community. Respondents reported that a better sense of self-respect and dignity, which they experienced in these groups, led to wider involvement, and that they now had more skills for dealing with people. Table 2 also illustrates the impact of CSDI involvement on issues such as self-confidence, feelings of being in control, coping, and feeling that choices are available.

The main factor that respondents cited as helping them to cope was the knowledge they had gained about various aspects of mental illness, including available services, resources, their rights, and the nature of the illness itself. Respondents commented that this knowledge enabled them to have choices and resulted in feelings of having control over their lives. Another factor that appeared to help respondents cope was the awareness that there are other people who share similar problems. According to respondents, this perspective gave them encouragement and a better understanding of their illness and themselves.

Relative Importance of Consumer/Survivor Organizations

In the opinion of those who use them, how important are consumer/survivor organizations? This is an important question in view of the fact that, at present, most governments in Canada and the United States invest the majority of their resources in hospital and community-based service models (Lurie & Trainor, 1992). As we have seen, CSDI organizations represent a different approach, which directly utilizes the skills and capacities of consumer/survivors to help each other and work together toward common goals. The members of CSDI groups who responded to the questionnaire in the second study are in the unique position of having experience with both traditional service models and with consumer/survivor

Table 3—Perceptions of Helpfulness and/or Harmfulness of Various Components of the Mental Health System

COMPONENTS OF MENTAL HEALTH SYSTEM	MEAN	SD
CSDI Groups	8.65	1.8
Other Self-Help Groups	7.23	2.3
Community Mental Health Agencies	6.76	3.2
General Hospital Psychiatric Units	5.81	2.9
Psychiatric Hospitals	5.42	3.1

Scores above 5 indicate a perception of helpfulness. Scores below 5 indicate a perception of harmfulness. CSDI groups are perceived to be more helpful than the other groups.

$p = .0001, N = 581-610$

Table 4—Perceptions of Helpfulness and/or Harmfulness of Various Individuals

INDIVIDUAL	MEAN	SD
Consumer/Survivors	7.9	2.0
Self	7.5	2.5
G.P./Family Physician	6.9	2.6
Friends (Non-Consumer/Survivors)	6.7	2.6
Therapists	6.5	2.7
Family	6.4	2.8
Nurses	6.4	2.7
Social Workers	6.3	2.7
Case Managers	6.0	2.9
Clergy	6.0	2.8
Psychologists	5.8	3.3
Psychiatrists	5.6	3.1

organizations. From the perspective of dealing with their mental health problems, respondents were asked to give their overall ranking of the helpfulness or harmfulness of CSDI groups and the various components of the service system. In addition to their consumer/survivor organization, study participants ranked community mental health services, general hospital services, and psychiatric hospital services. A multivariate analysis of variance was performed using a general linear models procedure with helpfulness/harmfulness of CSDI as the dependent variable. The results are shown in Table 3 and indicate that, although all services were perceived as beneficial, CSDI groups

were ranked significantly more helpful than all of the services. ($p = .0001$).

To further explore what consumer/survivors find helpful or harmful, study participants were asked to rank the helpfulness/harmfulness of various groups of individuals. CSDI organizations allow individuals more sustained contact with others who have directly experienced the mental health system, and it was considered important to see how they rank the impact of these individuals. Table 4 indicates that respondents ranked other consumer/survivors as the single most helpful group, higher than any professional category. This was significant at the $p = .0001$ level.

SUMMARY

The Consumer/Survivor Development Initiative in Ontario funds organizations that are required to meet two basic conditions: they must be consumer/survivor controlled and staffed, and they must carry out activities that reflect a model of action based on the principles of self-help and mutual aid (and not on the service model of provider-client). The results of this approach proved to be dramatic. Consumer/survivors involved in the groups report the following:

- They use significantly fewer mental health services after becoming involved with their group.
- They are able to increase their contacts with the wider community.
- They find consumer/survivor organizations the single most helpful component of the mental health system (when compared with psychiatric hospitals, general hospitals, and community mental health programs).
- They find other consumer/survivors (as individuals) significantly more helpful in dealing with their mental health issues than any professional group.

A review of funded organizations further indicates that while utilizing non-service models based on self-help and mutual aid, these organizations were able to engage in a range of activities that included, but went beyond, traditional self-help groups. The collective capacities of the consumer/survivors involved also addressed advocacy, cultural activities, knowledge development and skills training, public and professional education, and economic development.

DISCUSSION

The Ontario study reported here clearly demonstrates the positive impacts of consumer/survivor organizations and the importance that consumer/survivors attach to them. Despite this, there is evidence that consumer/survivor initiatives do not receive the level of support that their impact justifies. Only three Canadian provinces, for example, commit specific funding to these initiatives, and only one of these spends over 1% of its mental health budget on this sector (Trainor et al., 1993). In addition, a recent study by McLean (1995) suggests a serious degree of internal dissension and a loss of the emancipatory vision that used to permeate the consumer/survivor movement. Why is a successful model facing such difficulty?

The reasons for this situation are no doubt complex, but the results of this study indicate that the need to understand them is urgent. The earlier phases of deinstitutionalization, which were characterized by a critique of the incarceration of people with mental illness in custodial mental hospitals, or their abandonment in unprepared communities, created a clearly etched moral landscape. Consumer/survivors were not getting the services they needed and were being harmed as a result. While these issues remain important, they are now accompanied by more subtle and challenging issues for service providers and government planners. By saying that the help they receive from each other is more important than the help they receive from the mental health service system, consumer/survivors are sending a message much more fundamental than a simple call for more or better services. The message seems to be that mental health services, whether good or bad, are not nearly as central to consumer/survivors as they are to service providers. From the per-

spective of service providers, this is particularly challenging. It is one thing to be told that you should change the way you do things, but quite another to be told that your presence itself is less important than you had imagined.

This message is not new, but the change in thinking that it implies is Copernican in scale and is still far from understood. Mental health services have been the center of the professional universe for a long time. Not surprisingly, discussions in the field have been contained within certain boundaries that reflect this. Debates about whether services are best delivered in the community or the hospital, or by staff members with professional training or experience as consumers, are recurrent, while debates about whether or not service models themselves should in fact be the central focus of our approach to supporting people with mental illness are not. Most commonly, the new emphasis on the role of consumer/survivors is defined as being an adjunct in service provision. Consumer/survivors are cast as advisors, planners, and in some cases, as staff members of the service system (Chamberlin et al., 1996; Clark, Scott & Krupa, 1993; Morrell-Bellai & Boydell, 1994; Segal et al., 1995b). They may in fact control the organizations that offer services. While this is an important and valuable step in itself, it is not the same as recognizing the new landscape of consumer/survivor initiatives based on self-help and mutual aid, initiatives that are distinct and qualitatively different from services, not a modified version of them.

The distinction here can be seen most clearly from the vantage point of individual consumer/survivors. If the support they receive comes solely from service models, they will always play the role of client. They may be lucky and get excellent help, and the providers who offer it may themselves

be consumer/survivors, but this does not change their role as recipient. What is likely to be left untapped is their capacity to act on their own behalf and to help others, and it is this kind of opportunity that is brought to the forefront in self-help and mutual aid models (Rappaport, 1985). The study reported here suggests that an individual consumer/survivor should have the opportunity to benefit from both models; excellent services and collective action based on self-help and mutual aid.

The persistence of the idea that providing various services is all that we can do to support people with mental illness is a reflection of the dominance of the service paradigm. If the whole landscape is services, then everything that appears in it must be a version of them. This situation gets reflected in language, with perhaps the most striking example being the phrase "self-help services." From the perspective of the Ontario program this is clearly an oxymoron; the provider-client dynamic is simply incompatible with the principles of self-help, regardless of who is the provider. What is presumably meant by "self-help services" is service models where the providers are consumer/survivors. For the client, the fact that the worker who is providing counselling or case management is also a consumer/survivor clearly does not qualify the experience as one of self-help or peer support.

By creating initiatives that emphasize their collective skills and capacities to help each other, rather than the provider-client dimension of services, consumer/survivors are exploring fundamentally new ways of taking action on their own behalf (Mowbray et al., 1988). Although the approaches that they are using are most closely associated with the principles of self-help and mutual aid, it would be a mistake to assume that consumer/survivor organizations are traditional self-help groups. As

we have seen above, traditional self-help is only one of seven basic areas of activity. The new organizations are proving that their approach, while based on the basic principles of self-help and mutual aid, is applicable to a wide range of issues.

To get the job done, consumer/survivors need the financial tools, and if Ontario is an example, they may find support in unexpected places. In Ontario, the strongest support for the new programs (other than from consumer/survivors) came from the provincial mental health administration. Although the traditional role of bureaucrats has been simply to fund the service system, a new way of thinking has begun to emerge. The focus now is more on the rational investment of resources and can be seen this way: mental health systems have a certain amount of money to invest, and the basic purpose of this investment is to support people with mental illness and help them recover. Investments should therefore be made in whatever way is most effective for consumer/survivors. The current pattern of investment of most state and provincial governments is far too narrow. The portfolio should include a larger commitment to consumer/survivor organizations and to other approaches (for example family organizations).

A new approach by bureaucrats and administrators, which recognizes the role and value of consumer/survivor organizations, needs to be nurtured in an ongoing way. Although a strategy that allocates funds in a rational manner will naturally tend to support consumer/survivor initiatives, there are other factors that may not. Reductions in budgets and administrative rationalization can act against the development of new programs.

Mental health professionals are also essential allies in the development of consumer/survivor initiatives. Although

Reismann has stated that "professional help and self-help are approaches that are essentially in a dialectical relationship because professionals fear that peer helpers will do more harm than good, that self-help will interfere with the expansion of professional resources, and that professionals may lose control over the help provided as a commodity to be bought, sold, promoted, and marketed." (1990, pp. 226–228), there are other ways for professionals to frame the issue. Rappaport suggests that "the ideology of the community mental health movement can be consistent with the rise in legitimacy of self-help groups. In many ways, people coming together out of mutual concern—not for pay, nor as volunteers, but rather as peers mutually sharing their lives, without professional intervention—is the ideal of a strength-based, prevention oriented, empowering mental health system. In many respects community mental health professionals and self-help groups are natural allies" (1985, pp. 18–19).

For both government planners and professionals to effectively support consumer/survivor initiatives, it is essential that they recognize the important conceptual distinction between service models and the self-help and mutual aid models described in this paper. Consumer/survivors have critical roles to play in each, but the two approaches are distinct and offer different opportunities.

REFERENCES

- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16(4), 11–23.
- Anthony, W. A., & Blanch, A. (1989). Research on community support services. What have we learned? *Psychosocial Rehabilitation Journal*, 12(3), 55–81.
- Bachrach, L. L. (1981). Continuity of care for chronic mental patients: A conceptual analysis. *American Journal of Psychiatry*, 138(11), 1449–1455.
- Carling, P. J. (1993). Housing and supports for persons with mental illness: Emerging approaches to research and practice. *Hospital and Community Psychiatry*, 44(5), 439–449.
- Chamberlin, J. (1990). The ex-patients' movement: Where we've been and where we're going. *The Journal of Mind and Behaviour*, 11(3–4), 323–336.
- Chamberlin, J., Rogers, S., & Ellison, M. L. (1996). Self-help programs: A description of their characteristics and their members. *Psychiatric Rehabilitation Journal*, 19(3), 33–42.
- Clark, C. C., Scott, E. A., & Krupa, T. (1993). Involving clients in programme evaluation and research: A new methodology for occupational therapy. *Canadian Journal of Occupational Therapy*, 60(4), 192–199.
- Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11–19.
- Galantei, M. (1988). Zealous self-help groups as adjuncts to psychiatric treatment: A study of Recovery Inc. *American Journal of Psychiatry*, 145(10), 1248–1253.
- Kaufmann, C. L. (1995). The self-help employment centre: Some outcomes from the first year. *Psychosocial Rehabilitation Journal*, 18(4), 145–162.
- Lee, D. T. (1995). Professional underutilization of Recovery Inc. *Psychiatric Rehabilitation Journal*, 19(1), 63–70.
- Lurie, S., & Trainor, J. (1992). Mental health policy and expenditure analysis: Tools for change. *Canada's Mental Health*, 40(1), 11–14.
- Macnaughton, E. (1992). Canadian mental health policy: The emergent picture. *Canada's Mental Health*, 40(1), 3–10.
- McLean, A. (1995). Empowerment and the psychiatric consumer/ex-patient movement in the United States: Contradictions, crisis and change. *Social Science and Medicine*, 40(8), 1053–1071.
- Morrell-Bellai, T. L., & Boydell, K. M. (1994). The experience of mental health consumers as researchers. *Canadian Journal of Community Mental Health*, 13(1), 97–110.
- Mowbray, C. T., Chamberlain, P., Jennings, M., & Reed, C. (1988). Consumer-run mental health services: Results from five demonstration projects. *Community Mental Health Journal*, 24(2), 151–156.
- Murphy, H. B. M., Pennee, B., & Luchins, D. (1972). Foster homes: The new back ward? *Canada's Mental Health*, 20(5), Supplement No. 71.
- Noh, S., & Turner, R. J. (1987). Living with psychiatric patients: Implications for the mental health of family members. *Social Science and Medicine*, 25(3), 263–271.
- Ontario Ministry of Health. (1993). *Putting people first*. Queen's Printer for Ontario: Toronto.
- Omark, R. C. (1979). The dilemma of membership in Recovery Inc.: Self-help ex-mental patients' organization. *Psychological Reports*, 44, 3(2), 1119–1125.
- Powell, J. T. (1975). The use of self-help groups as supportive reference communities. *American Journal of Orthopsychiatry*, 45(5), 756–764.
- Rapp, C. A., Shera, W., & Kisthardt, W. (1993). Research strategies for consumer empowerment of people with severe mental illness. *Social Work*, 38(6), 727–735.
- Rappaport, J. (1985). The power of empowerment language. *Social Policy*, 15–21.
- Reissman, F. (1990). Restructuring help: A human service paradigm for the 1990s. *American Journal of Community Psychology*, 18(2), 221–230.
- Segal, S. P., Silverman, C., & Temkin, T. (1993). Empowerment and self-help agency practice for people with mental disabilities. *Social Work*, 38(6), 705–712.
- Segal, S. P., Silverman, C., & Temkin, T. (1995a). Characteristics and service use of long-term members of self-help agencies for mental health clients. *Psychiatric Services*, 46(3), 269–274.
- Segal, S. P., Silverman, C., & Temkin, T. (1995b). Measuring empowerment in client-run self-help agencies. *Community Mental Health Journal*, 31(3), 215–227.
- Shelton, R., & Rissmeyer, D. (1989). Involving consumers in the discharge process. *Psychosocial Rehabilitation Journal*, 12(4), 19–28.
- Spaniol, L., & Koehler, M. (Eds.). (1994). *The experience of recovery*. Center for Psychiatric Rehabilitation. Sargent College of Allied Health Professions. Boston University.
- Spaniol, L., Koehler, M., & Hutchinson, D. (Eds.). (1994). *The recovery workbook: Practical coping and empowerment strategies for people with psychiatric disability*. Boston: Center for Psychiatric Rehabilitation.
- Specht, D. (1988). *National survey on State support of consumer/ex-patient activities in mental health*. Holyoke, MA: Human Resource Association of the North East.
- Talbott, J. A. (1979). Deinstitutionalization: Avoiding the disasters of the past. *Hospital and Community Psychiatry*, 30(9), 621–624.
- Trainor, J., Pomeroy, E., & Pape, B. (1993). *A new framework for support for people with serious mental health problems*. Published by the Canadian Mental Health Association Toronto.
- Trainor, J., & Tremblay, J. (1992). Consumer/survivor businesses in Ontario: Challenging the rehabilitation model. *Canadian Journal of Community Mental Health*, 11(2), 65–71.
- Wollert, R. W. (1986). Psychosocial helping processes in a heterogeneous sample of self-help groups. *Canadian Journal of Community Mental Health*, 5, 63–72.
- Zimmerman, M. A., Reischl, T. M., Seidman, E., Rappaport, J., Torvo, P. A., & Salem, D. A. (1991). Expansion strategies of a mutual help organization. *American Journal of Community Psychology*, 19(2), 251–278.