CONSUMER/SURVIVOR-RUN BUSINESSES:
COMMUNITY ECONOMIC DEVELOPMENT AND SELF-HELP
FOR PEOPLE WITH A HISTORY OF MENTAL ILLNESS

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE
in
THE FACULTY OF GRADUATE STUDIES
School of Community and Regional Planning

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
October 1994

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Date Oct. 14, 1993
Consumer/survivor-run businesses (CSRB's) are businesses in which people with a history of mental illness play a role in developing and managing the business. Key aspects of this type of activity include flexibility in working hours, and some form of democratic control over the business.

Consumer/survivor-run businesses employ aspects of both community economic development and self-help for people with a history of mental illness.

These businesses act as an alternative form of vocational rehabilitation for people with a history of mental illness. The predominant forms of vocational rehabilitation, such as sheltered work, employment preparation programs, transitional employment, and supported employment are often beneficial, but are not without limitations. Dependency on professionalized services, stagnation in entry-level jobs, and a lack of independence are some of the limitations described in the literature.

Five cases of CSRB’s from across Canada are analyzed. From the literature reviewed and the experiences of these cases, constraints faced by CSRB’s and opportunities presented for support to them through public policy are discussed.

The constraints included (i) bureaucratic restrictions that limit what consumer/survivors may earn on top of their disability pensions; (ii) attitudes of the general public, namely the stigma of mental illness; (iii) attitudes of mental health professionals, who hold to a ‘service paradigm’; (iv) problems inherent in the development of alternative settings, and (v) the drift towards professionalism often experienced by alternative settings.
Opportunities presented for the development of CSRB’s include: the benefits that CSRB’s hold for consumer/survivors (flexibility in hours, stable employment, a sense of self-reliance and independence); the economic climate (high unemployment, high public debt, etc.) which will make traditional forms of vocational rehabilitation less viable. Government support, including the provision of ongoing funding and technical support for CSRB’s, could aid in the development of this type of alternative setting.
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1.0 Introduction

My purpose in this thesis is to analyze a new field, bridging community economic development and self-help for people with a history of mental illness: consumer/survivor-run businesses (CSRB's). From a review of the relevant literature, and of Canadian CSRB projects, characteristics of this activity, constraints to their development, and opportunities will be identified. A potential provincial strategy for supporting CSRB's will then be outlined.

First, some terminology. 'Consumer' in this context, describes someone who, due to mental illness, has sought help from the mental health system. This term has come to be preferred by people with such experiences, over such terms as 'patient' or 'client'; the term 'consumer' gives to the individual who consumes mental health services the notion of someone who has rights to fairness and proper treatment.

'Survivor' is preferred by people who claim they have found themselves in the care of the mental health system due to traumatic events in their lives, rather than a mental illness. Such people do not consider themselves as mentally ill per se, but as victims of a mental health system they see as oppressive.

Consumer/Survivor-run businesses are enterprises in which people with a personal experience of the mental health play a guiding role. Two important aspects of this model are:

(i) CSRB's attempt to make the workplace more suitable for consumer/survivors rather than trying to make the consumer/survivor fit the workplace. Flexibility is incorporated into the enterprise; members may replace each other on the basis of health factors.
Where people may not be able to work full-time, they may be able to work part-time, or work a schedule that allows for medical- and social service-related absences.

(ii) CSRB’s, to a varying degree, employ a membership-driven process, enabling members to play a role in developing and managing the enterprise.

What is the rationale for CSRB’s? Following the onset of mental illness, many people become largely disabled, and are unable to work. Lacking a role in the community, these people may become progressively more withdrawn and isolated. To combat such isolation and develop vocational and life skills, vocational rehabilitation programs have been developed.

The sheltered workshop has been the most common form of vocational rehabilitation. Work, in these settings, requires a low skill level; payment is a token sum, usually below minimum wage. Criticism of sheltered workshops has focused on ‘institutional dependency’, a lower level of functioning that comes to be accepted as normal. With little opportunity to develop self-reliance and independence, people remain at a low level of functioning. This criticism has led to the development of other models of vocational rehabilitation, such as supported employment and transitional employment.

Supported employment is a model in which the client is placed in a ‘real’ job, and is provided with access to ongoing counselling support. Transitional employment refers to a model in which vocational training is followed by job placement and substantial support for a transitional period.

While representing an improvement over the sheltered workshop
environment, the supported employment and transitional employment models are also now facing criticism. The jobs that clients are placed in tend to be entry-level and low paying. And dependency may be a problem. Despite these vocational rehabilitation measures, the full-time employment rate for people who have been hospitalized with a mental illness has been estimated to be only 20% (Canadian Institute of Cultural Affairs, 1984).

The rationale for CSRB’s is that while existing forms of vocational rehabilitation serve some who have a mental illness, alternative models which provide for a greater level of self-reliance are needed.

Brown (1989) analyzed the worker co-operative model of business organization, and its applicability to vocational rehabilitation and the development of employment opportunities for the psychiatrically disabled. Based on a case study of A-Way Express Couriers, she concluded that this model provided more opportunities for self-reliance and self-determination than other forms of vocational rehabilitation. For those consumer/survivors who are able to function in a business setting, CSRB’s are an especially appropriate option.

Recently, a survey was completed in Ontario that attempted to measure the impact of CSRB involvement on the use of mental health services by consumer/survivors. The survey found that involvement with CSRB’s resulted in significant decreases in the number of days spent in hospital, days spent in out-patient programs, and crisis contacts (Trainor & Tremblay, 1992).

CSRB’s attempt to redefine the worker’s relationship with the employment setting. They are collective efforts to create work that
is meaningful by virtue of the worker's stake in the enterprise. As such, CSRB's are a form of community economic development initiative.

Recently, policy makers and planners have caught up to the trend of mental health consumers taking control over their lives. Recent mental health policy statements put out by provincial governments have included commitments to self-help initiatives. In British Columbia, funds are granted via the Consumer Initiative Funding program. One of the B.C. organizations funded, the West Coast Mental Health Network, is interested in CSRB's, and a couple of enterprises are in the planning stage. Ontario has been leading the way with consumer initiatives. In 1991, the provincial government set up the Consumer/Survivor Development Initiative (CSDI). Since 1991, 34 self-help projects have been set up by consumers across Ontario. These range from counselling, advocacy, and activity groups, to economic initiatives. Five of the projects funded by CSDI are CSRB's.

It would seem to be beneficial that more experiments with CSRB's be developed. With more examples will come more information on how this model can work.

1.1 Methodology

Five examples of CSRB's were analyzed in this thesis. Three of these, A-Way Express Couriers, Abel Enterprises, and Fresh Start Cleaning and Maintenance, all located in Ontario, were selected for analysis because they are the oldest, most established examples of CSRB's. The selection of three examples which have been successful could be viewed as biased; on the other hand, looking at
successful examples allows the analysis of why these examples have survived -- why have these particular projects been successful?

Other examples in Ontario were not used, as they were newer, less established, and there was not as much information available on these.

The other two examples selected are from the Vancouver area. Less information was available on these as they are also very new (Unity Housing having been in operation for a year, the Consumer/Survivor Artists’ Cooperative less than one year). These were chosen to give an idea of the diverse nature of activity occurring.

Information on the five examples of CSRB’s studied in this thesis was extracted from (i) existing literature on these examples; and (ii) brochures and information sheets issued by the projects themselves.

Personal interviews with people involved with the primary examples would have been difficult, given the fact that they are located in Ontario. And, as mentioned, the two local examples have just begun operation.

A number of sources were drawn upon to analyze A-Way Express Couriers; these ranged from Brown’s 1989 thesis, journal articles (Trainor & Tremblay, 1992; Ward & Tremblay, 1988), Consumer/Survivor Development Initiative promotional material, and newspaper articles.

Similarly, to analyze Abel Enterprises, a number of sources were used (Canadian Institute of Cultural Affairs, 1984; CMHA, 1987; CSDI, 1994; Trainor & Tremblay, 1992). Only two sources were used for Fresh Start Cleaning and Maintenance (CSDI, 1994; Trainor
Information for the discussion of the context for CSRB's (relating to the areas of mental health policy, vocational rehabilitation, community economic development, and perspectives on the disabled) was gathered primarily from library research, and from agencies involved with mental health.

Some insight into issues affecting consumer/survivors was obtained through talking with people involved with the West Coast Mental Health Network, an organization representing consumer/survivors, and volunteer work with the Canadian Mental Health Association.

This thesis does not attempt to systematically analyze the benefits of CSRB's, or ask whether this model can work. Brown (1989), in her research, looked at these questions and found that CSRB's were viable, and were beneficial to consumer/survivors. This thesis attempts to bring a planning perspective to this area. Constraints to the development of CSRB's, and reasons that they have worked, are analyzed from a public policy perspective. From the lessons learned, a broad strategy for supporting CSRB's is proposed.
2.0 Context for Consumer/Survivor-run Businesses

2.1 Mental Health Policy

In order to analyze Consumer/Survivor-Run Businesses and what a supportive provincial strategy could look like, it is necessary to review mental health policy, including the historical treatment of the mentally ill, Canada’s approach to mental health, and recent trends in mental health policy.

2.1.1 Historical Treatment of the Mentally Ill

A review of treatment of the mentally ill through history yields many examples of horrific treatment. Early New Englanders, thinking symptoms of mental illness were signs of demonic possession, burned and tortured mentally ill people. In later years, the mentally ill were incarcerated with criminals, or thrown in poor houses. However, in many cases mentally ill people were cared for at home by their families (Brown, 1990).

With the advent of professionalism in the 19th century, the mentally ill were distinguished from the retarded, elderly, and insane. Public provision for care of the mentally ill was initiated. Philippe Pinel, a French doctor and social reformer, worked for better treatment of mentally ill people; he believed that people could be rehabilitated, through respectful and sympathetic treatment, in an institutional setting. Pinel referred to his methods as ‘moral treatment’. His asylums reported good rates of cure.

As a result of positive developments such as this, asylums for the mentally ill became more widespread in the 19th century. Increasing urbanization and the loss of traditional ways led to
more people being treated in institutions instead of at home. This resulted in institutions becoming more crowded; care became increasingly impersonal and bureaucratized. Having formerly provided a curative environment, institutions now lost their efficacy. Public opinion turned against institutions, leading to cuts in government funding, causing conditions to become poorer and more crowded (Brown, 1989).

2.1.2 The 20th Century

In the 20th century, a number of developments led to a reassessment of institutionalization. The onset of psychoanalytic theory caused a change in how the nature and causes of mental illness were regarded; environmental and emotional factors came to be seen as important in the treatment of mentally ill people. Psychoactive drugs, introduced in the 1950’s, decreased some of the symptoms of mental illness. The human rights movement of the 1960’s led to an appreciation of patients’ civil rights. These developments led to a movement towards deinstitutionalization of patients.

Governments, subject to financial pressures, went along with calls for deinstitutionalization. But there was a failure to appreciate the result releasing people into the community without new systems of support would have.

2.1.3 The Canadian Context

Canadian mental health policy has experienced several shifts in recent decades. From 1950 to 1960, the institutional system was expanded and improved. There were large increases in the number of
professional, administrative, and nursing staff during this time; 18,000 new beds were provided in psychiatric and general hospitals (Trainor et al., 1992).

The Canadian movement towards deinstitutionalization of patients was spurred by the release, in 1963, of the Canadian Mental Health Association report *More for the Mind* (Griffin et al., 1963). Subsequently, from a total of 69,359 beds available in 1963, the number of beds were cut to 22,551 by 1977 (Statistics Canada, 1977). In addition, *More for the Mind* called for community psychiatric services which would enable the mentally ill to live in the community.

### 2.1.4 Problems with Deinstitutionalization

The move towards community services was poorly planned. While provision was made for medical and therapeutic services in the community, no provision was made for other necessities that had been provided for in institutional settings, such as housing, vocational programs, and income.

By 1980, large numbers of former patients were existing in the community in substandard housing and with inadequate support. Many ended up returning to hospital. While the length of stay at psychiatric hospitals was shorter, the number of readmissions of chronically mentally ill individuals had increased. Clearly, deinstitutionalization was not working.

Brown (1989) convincingly says that deinstitutionalization’s failure was due to the failure of professionals to provide a systematic plan of coordinated community care programs that would assist patients to make the transition to living in the community.
More supports for patients returning to the community were required.

In response to this situation, more community mental health centres, and agencies to help consumer/survivors with necessities such as housing and vocational rehabilitation, have been created.

2.1.5 Challenges to Community Care

Despite the advances, existing forms of community care are increasingly being challenged. The challenges identify a 'service paradigm' (Trainor et al., 1992). The underlying assumption of the service paradigm is that certain numbers of people in society will become ill, and that the service system is there to provide treatment for those individuals; planning in this area is to be geared towards improving the level of service available to the afflicted.

Those who challenge the service paradigm suggest that improvements in the health care system have not played a very large role in the improvement of public health; they point instead to basic public health measures and lifestyle changes. A World Health Organization study of schizophrenia dramatically underscores the point of those who criticize the service paradigm:

This study clearly demonstrated that the sophisticated treatment approaches of western nations are no match for the dramatically marginalized positions to which these nations relegate the person with schizophrenia. All the technology and sophistication of our treatment methods have been unable to produce outcomes which are as good as those in a Third World village. (Trainor et al., 1992, p. 26)

2.1.6 The Development of Psychosocial Self-Help Clubs
In response to deinstitutionalization and the lack of services available to consumer/survivors, many non-professionals and patients developed psychosocial self-help clubs. The first clubs, Fountain House and Horizon House, provided mutual support networks for ex-patients, providing members with the opportunity to develop social skills, friendships, and assistance in the location of housing and employment. The philosophy of such clubs is that members can support themselves in the community with a limited degree of support, without extensive professionalized services.

2.1.7 Canadian Mental Health Policy - The Emergent Picture

In a survey of recent provincial policy documents, Macnaughton (1992) reflects on some of the needs becoming noticeable in mental health policy. Macnaughton summarizes these needs as follows:

1. A need for establishing clear priorities as to whom the mental health system should support;

2. The need for reallocation of resources (both fiscal and human);

3. The need for coordination of the mental health system;

4. Regionalization/Decentralization of administration and service delivery;

5. Individualization of planning and service delivery;

6. Consumer and family participation in the mental health system;

7. The need to provide opportunities for self-help and mutual aid (Macnaughton, 1992, p. 7-10).

The first priority described by Macnaughton, establishing
clear priorities, refers to the need to allocate funds to those
groups who most need the money. The most noticeable aspect of this
trend is that of increasing the support for community services, and
therefore decreasing the influence, and support for, institutional
settings.

The second trend, the need for reallocation of resources, also
deals primarily with the relationship between support for community
services and support for institutional settings. Once again, recent
provincial policy documents are clearly in favour of community
support services.

The last two policy trends listed by Macnaughton have direct
relevance to the development of consumer/survivor-run businesses.
Macnaughton describes a trend toward family and consumer
participation in the mental health system. Through their
experiences, consumers and their families often become interested
in political involvement aimed at changing the mental health
system. New Brunswick, Alberta, and Saskatchewan have allowed for
consumer participation on planning boards. Through written policy
and practise, provincial governments are now trying to recognize
the concerns of consumers and their families, with consultation
processes including consumer and family representatives
(Macnaughton, 1992).

Most recent mental health policy documents reflect a need for
strengthening opportunities for self-help and mutual aid.

...emerging mental health policy reflects a trend away
from...the "service mentality", i.e. the implicit belief
among many professionals and policy-makers that consumers
should be simply passive recipients of drugs, psychotherapy,
or whatever programs are prescribed for them (Macnaughton,
New Brunswick’s Mental Health Commission funds more than 30 self-help groups or activity centres run on the self-help model. In Quebec, funding for self-help initiatives is provided through "Regroupement des Ressources Alternatives en Sante Mentale".

In British Columbia, a number of self-help initiatives exist. The B.C. Ministry of Health provides ‘Consumer Initiative Funding’. These funds, $5 Million for the past year, goes to the Greater Vancouver Mental Health Society (GVMHS). Mental health advisory committees make decisions about how the money will be spent. At present, there are four projects: Unity Housing, The Kettle Advocacy, the Vancouver-Richmond Mental Health Consumer Constituency project, and the Consumer/Survivor Artists’ Cooperative.

2.1.8 The Sector-Based Model

Deinstitutionalization, and the crisis situation it brought on in the early 1980’s, led to the formation, by the Canadian Mental Health Association, of the Mental Health Services Committee, which in turn launched a research initiative to assess how people could best be supported in the community. This was to lead to a policy position for people with serious mental illness. A Framework for Support for People with Severe Mental Disabilities (Trainor & Church, 1984) was published, outlining a set of principles that have guided the CMHA’s ongoing project "Building A Framework for Support". This project’s aim is to ensure that people with mental illness live ‘rich and fulfilling lives in the community’ (Trainor
et al., 1992). The two basic requirements identified to make this happen were:

1. that individuals with mental health problems be empowered to control their own lives and to make choices about which supports to utilize; and,

2. that the community be mobilized to use all its capacity to support people with mental health problems (Trainor et al., 1992, p.26).

The movement from institutionalized care to an emphasis on community services constituted a paradigm shift; living in the community, supported by various programs, was seen to be better than being sheltered from the community in an institution. The philosophy lying behind this shift was that systems are perfectible - that what was needed was better ways of providing services to people. However, there is a growing realization that even community service settings may not fully develop people’s potential. With the realization that community services may still foster dependency and separate people from the community, a second paradigm shift is becoming apparent.

There is a dawning awareness that non-service approaches, such as self-help and mutual aid, may provide opportunities for personal growth that service approaches do not.

Both as categories of human action and in the way in which they provide assistance, activities such as self-help are not services. They differ qualitatively in the way they see and classify an individual, and thus offer opportunities for friendship and belonging which services do not. They also have substantial potential to address the isolation and alienation felt by many people with mental illness (Trainor
et al., 1992, p. 26).

Through the CMHA's Framework for Support and other reports, a realization is evident that policy needs to reflect the fact that consumers now play a central role in their own support and community survival (Trainor et al., 1992).

As an alternative to the service paradigm, Trainor describes a Community Process Paradigm, which instead of focusing on the provision of services, focuses on the community's overall support. In this paradigm, the role of (i) families and informal networks, (ii) consumers themselves, (iii) generic community agencies and groups are included along with the role of (iv) the formal mental health system. The model - that encompasses these four components - is referred to as the Community Resource Base Model (Trainor et al., 1992).

Figure 1. The Community Resource Bank

<table>
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<tr>
<th>Consumer Self-Help</th>
<th>Families and Informal Networks</th>
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<td>Person</td>
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<td>Generic Community Agencies and Groups</td>
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</table>

The role of professional mental health services is still seen as crucial, but becomes recognized as only one of four sectors that
are put into play in the support of the individual. The Framework model, in practise, would direct three fundamental changes in policy.

1. Consumers and families would have a role as far as developing self-help and mutual aid initiatives, and advocacy. Support for such initiatives would be needed.
2. Consumers and families would have a role in the development of policy; in planning, developing, and monitoring services; generic social agencies would also have a role, as appropriate.
3. The role of government becomes one of supporting all the sectors; instead of their former role of administering the service system (Trainor et al., 1992, p. 27).

2.1.9 Summary

The limitations of institutionalized care led to deinstitutionalization and the provision of community services. More recently, the community care system has been criticized. The most recent trend has been towards self-help and mutual aid approaches. Consumer/survivor-run businesses are part of this trend towards non-service approaches in the mental health field. Recent policy documents have encouraged the development of such non-service approaches. The CMHA report 'Framework for Support' encourages a Community Resource Bank, emphasizing that consumers have a place in developing self-help initiatives, and that mental health policy should reflect this.
2.2 Vocational Rehabilitation for the Mentally Ill

Consumer/survivor-run businesses are presented by authors such as Trainor & Tremblay (1992) as an alternative to existing vocational rehabilitation programs. To discuss this field, its dimensions, and what a provincial strategy that supported them would look like, it is necessary to review existing forms of vocational rehabilitation.

Vocational rehabilitation for the physically disabled became widespread after the Second World War, in response to the needs of disabled veterans. Programs designed to meet the needs of the physically disabled were used to meet the needs of other disabled, including individuals with a mental illness. With deinstitutionalization, the demands placed on these services increased dramatically.

The differences between the European and American approaches to vocational rehabilitation need to be clarified at this point. The European perspective on vocational rehabilitation has tended to be based on a philosophy that employment is a right for all citizens; this has included a commitment to full employment for the psychiatrically disabled, and has led to an expectation that government provide work for this population. This commitment has been accomplished in two ways: (i) through a system of quotas for disabled workers, applying to both the private and public sectors, legislated in most European countries; and (ii) through the provision of sheltered work, which in Europe is viewed as substitute permanent employment (Brown, 1989).

In the United States, where the process of deinstitutionalization has occurred much more rapidly, philosophies
and approaches to rehabilitation have been much more person- and problem-oriented than in Europe. Professionals such as psychiatrists, psychologists, and social workers have a larger role in the American approach to rehabilitation; rehabilitation and job placement tend to be made on the basis of evaluative and diagnostic assessments. Rehabilitation consists of a series of steps, beginning in the institution, and gradually progressing to different forms of work. Recently, there has been a realization that more flexibility is needed in vocational programming. This is based on the observation that not all patients follow the same path; some may relapse, and need to follow a different rehabilitation schedule. European approaches, such as supported work, have been receiving increased emphasis in the United States in recent years.

Vocational programs may be described as falling into four broad categories:

1. Employment Preparation Programs
2. Sheltered Work
3. Transitional Employment
4. Supported Employment

2.2.1 Employment Preparation Programs

Employment preparation programs vary from work adjustment programs, to career counselling, occupational training, and career placement training programs (Cochrane et al., 1990).

Work adjustment programs are oriented towards assisting patients to fit into a competitive work environment. This is done by assisting patients in the development of job-related skills.
Such programs may deal with such issues as punctuality, motivation to work, communication skills, and appropriate dress and behaviour. Most often, these programs are offered in sheltered settings. Increasingly, these programs may be offered in community settings, where there is a focus on the acquisition of job-related skills through daily living.

Occupational skills training programs deal with the acquisition of job-specific skills, and usually occur after completion of work adjustment programs and career counselling.

Career placement training programs aim at assisting clients in the development of effective job search and marketing techniques. Elements of career counselling, pre-employment counselling, work adjustment training, marketing and motivational training are employed in such programs.

For example, the Vancouver-Burnaby Branch of the Canadian Mental Health Association has two programs that deal with employment preparation. The CMHA’s Vocational Services program offers vocational and pre-vocational training to individuals who have or have had a mental illness. This program offers life skills, work skills (including work adjustment as well as skill training), and computer skills. CMHA also has an Employment Services program which offers a range of services including vocational testing, career counselling, job search techniques, job coaching, placement, and follow-up support.

2.2.2 Sheltered Work

Sheltered work, until very recently, has been the most common form of vocational rehabilitation. The rationale for sheltered work
has been the emotional and physical benefit patients derive from engaging in productive activities. These facilities have operated traditionally by soliciting work from industries, which is then carried out by patients. The workshops usually provide a heavily structured environment, with a regimented routine of vocational training, counselling, and recreation. Workshops such as these are intended to provide an environment where patients can develop their vocational and social skills, and assist with the transition from hospital to community.

At these settings, the work done by patients tends to be menial in nature. Patients often received nothing, or only a token sum for their work. At the same time, hospitals came to depend on this source of cheap labour. Work tended to be based on the needs of the institution, rather than the needs of the patient (Cochrane et al., 1990).

Most recent studies suggest that the highly structured nature of these workshops does not provide an environment where patients can develop their skills, rather, patients tend to become dependent on the sheltered setting (Trainor & Tremblay, 1992).

Brown notes that acquired social and psychological factors surrounding the disability are actually more of an obstacle than the disability itself. Brown states further:

...staff who have not reflected critically upon the assumptions of their training and practise may be unable to envision workshop alternatives that would truly develop the client's potential (Brown, 1989, p. 17)

2.2.3 Transitional Employment

Increasing disillusionment with traditional sheltered workshops led to a search for alternative forms of vocational
rehabilitation. One such alternative came to be called transitional employment. These programs provide short-term (typically 3 months to one year) work placements in regular, competitive settings. Usually these placements are half-time, so that two clients can share one job.

Transitional employment programs typically benefit individuals who have vocational skills, and are as such employable, but who require a situation where their social functioning and level of work adjustment can be improved. In this way, transitional employment programs can be seen to differ from sheltered workshops in that there is more emphasis on clients’ abilities rather than disabilities.

The job placements typically are entry-level positions. Some clients upon completion of their placement, are hired on by the company.

Although the placements are temporary, the positions are not; upon completion of the placement, a new client will take over the position.

The major incentive for companies to use transitional employment programs is that sponsoring agencies train the client for the job; and ensure that if, for any reason, the client misses a shift, a backup will be provided. Clients have access to treatment staff at all times. Work performance is often actually higher for clients from transitional employment programs than for regular employees (Cochrane et al., 1990).

An example of a transitional employment program from the Vancouver area is the Coast Transitional Employment Program. The Coast Foundation was founded in 1974 to provide quality housing,
job readiness training, social and employment opportunities for people challenged by psychiatric illness. One of the programs offered by Coast is a Work Readiness program that prepares members for re-entry into the job market. The major components of the work readiness program are the Work Units where job-oriented tasks are performed on a daily basis. Members develop work adjustment skills, self-esteem, and confidence (Coast Foundation, 1993).

COAST’s Transitional Employment Program (TEP) provides members who have developed their job skills a means of re-entering the workforce. As with other transitional employment programs, TEP placements are part-time and temporary, and are paid at competitive rates. Initially, a COAST employment counsellor works with the client to learn the job, and ensure that it is being done to the employer’s standards. COAST ensures that should a client need to miss a shift, a backup will be provided; on-going monitoring and support are also provided. Typically, a client will work on the job for 6 months and then move on to another position, allowing the client to gain experience in different work environments.

Employers who use the TEP program come from a variety of industries, ranging from small family-based businesses to major corporations; employers include St. John the Divine Day Care Centre, United Services Credit Union, Canadian Tire and Goodrich Realty (Coast Foundation, n.d.).

2.2.4 Supported Employment

Another alternative to the sheltered workshop that has become common is supported employment. Whereas in the transitional employment model, training occurs before job placement, in
supported employment, placement occurs first. The client is provided with training while on the job, ensuring that training is appropriate and job specific. And where transitional employment provides temporary placements for clients, with supported employment clients are placed in jobs that are permanent; likewise, support is ongoing.

Clients are involved in identifying what type of work would suit their interests, abilities, and aspirations; work placements are usually in entry-level positions, though sometimes non-entry level positions with career possibilities may be offered.

Supported employment is thought by some researchers to be appropriate for those who need support in order to function in the competitive marketplace, but who function too well to be limited to transitional employment (Cochrane et al., 1990). Other researchers have noted that some individuals labelled ‘permanently unemployable’ in other programs, are able to cope well in a competitive business environment, provided they have proper support (Brown, 1989).

The rationale for supported employment is that training in a competitive work setting is thought to be more efficient and has a better chance of leading to success than training in a sheltered setting, or pre-vocational training; further, supported employment is seen to maximize the fit between the client, the employer, and the job. Supported employment is seen to provide for greater client independence, and lessen the ‘institutional dependency’ that some researchers feel such programs as sheltered workshops and transitional employment create. A study from Maryland, cited in Bond (1987), found that only 5% of clients in transitional
employment went on to competitive employment; the study suggested that staff in transitional programs may be reluctant to lose their better workers to the competitive workforce.

Despite the successes and positive aspects of supported employment, not all disabled workers find it the best alternative. Chronic psychiatrically disabled workers may still find it difficult to maintain competitive employment in the public or private sectors (Brown, 1989), due to such issues as absenteeism, negative stereotypes, and poor work records. These issues have been used as a rationale for the development of a variation of supported employment, the worker co-operative model.

2.2.5 Summary

Vocational rehabilitation in North America generally takes the form of (a) employment preparation programs, (b) sheltered work, (c) transitional employment, and (d) supported employment. This range of options doesn’t provide for all mentally ill individuals; new alternatives are needed.

The worker co-operative model differs from other forms of supported employment in that it enables patients to develop, own, and operate the business in which they are employed. This model will be described further in Chapter 3, "Consumer/Survivor-Run Businesses".

2.3 Community Economic Development

Consumer/Survivor-run businesses offer promise as an alternative model of vocational rehabilitation. It is important at this stage to put this model in context, as a specific tool of community economic development. A discussion of community economic
development will provide insight into what CED is, the various ways in which it may be operationalized, and what issues regarding CED are relevant.

Community economic development has been defined in a number of different ways. One particularly clear definition is:

... a process whereby people in a community organize themselves and pool their resources with the available resources from government, churches, and other groups to solve local economic problems (Catholic New Times, Dec. 20, 1992, p. 13).

Community economic development is ideal for marginalized communities, in that it has the capacity to make use of unrecognized strengths of marginal communities - particularly available labour and other unused resources. CED strategies place particular emphasis on decentralized, labour-intensive projects, which find uses for available resources.

People who have been hospitalized with a mental illness have a very high rate of unemployment. The available resources this group has to offer are their available labour and unused talents. Community economic development projects could provide an opportunity for these people to employ their talents and available time.

2.3.1 The concept of ‘community’ in community economic development

Different authors have different conceptions of ‘community’ as it pertains to community economic development. Fontan (1993) makes a typology of these different conceptions.
1. **A Geographic Base**, where community economic development is attempted in a specific geographical area, particularly a marginalized urban or rural area;

2. **A Social Base**, where community economic development is geared toward a specific social group, particularly marginalized groups in society (the unemployed, women, the young, the disabled,...);

3. **A Community Base**, where community economic development is developed in a location, where residents share a strong shared interest; or a common history and sense of belonging.

In the case of consumer/survivor-run businesses (CSRB’s), community economic development is attempted with a social base, with a group of people in society who have been marginalized.

Perry (1987) and MacLeod (1986) assert that community economic development must be based in a specific geographic locality, in order that there be developed a local level representative of the population as a whole, to which power can be transferred back.

Power over the lives of consumer/survivors has traditionally resided with representatives of the traditional mental health system -- institutions, community service agencies, and professionals. Self-help and mutual aid initiatives, of which consumer/survivor-run businesses are an example, may assist consumer/survivors to take back control over their lives.

2.3.2 Dimensions of Community Economic Development

The aspects of community life toward which community economic development may be directed can be divided into four areas. In the next two sections, it is not my intention to give a detailed account of CED’s dimensions, and the tools that are used to operationalize CED; rather, this a sketch of the terrain, such that we can see where CSRB’s fit into the larger picture.

1. Land Use Planning:
Community initiatives oriented towards gaining control over land use, or to improve the physical or socioeconomic infrastructure through:

   (i) housing

   (ii) zoning, in which a community attempts to affect land use in a given area

   (iii) collective land ownership, affecting environmental, residential, commercial, or industrial purposes.

2. Employment:
Initiatives directed toward the development of the community’s human resources, through:

   (i) the development of employability; promoting the development of job skills through pre-employability or vocational training.

   (ii) job training; providing a given clientele training with a community enterprise.

3. Private or Collective Entrepreneurship:
Initiatives geared toward assisting business development in the community through:
(i) private or collective business development assistance; through such measures as technical resource groups, training individuals or groups to set up businesses;
(ii) the development of community enterprises;
(iii) business incubators; tools used in conjunction with new business development;
(iv) early warning systems; identifying plants in danger of closing, and intervening to keep them in operation;

4. Private or Collective Investment:
Initiatives to mobilize financial resources for community development.

(i) private banks, which have a social orientation, or co-operative banks;
(ii) community loan funds, assisting the community in managing of loans of venture capital for social initiatives.

Fontan describes the tools of intervention developed by social activists to operationalize CED (Fontan, 1993). These he divides into two categories. As explained below, the first category is those intervention tools which take a plural, or global approach towards community economic development. The other category is for those tools which take a singular, or specialized, approach.

Global Intervention Tools

The primary example of a global intervention tool is the community development corporation (CDC). A CDC is a non-profit organization, with a board of directors including representatives of the business and social service sectors, and direct
representation from residents of the community.

Community Development Corporations share some aspects with co-operatives. Both are structures set up with the intention of combining social purpose with economic activity. Yet CDC’s usually carry out diverse functions not fitting under the present laws governing co-operatives.

Corporations are set up to accumulate larger amounts of capital than a small business could. Limited liability encourages risk-taking: while a corporation may go bankrupt, employees are shielded from liability. An employee of a corporation could conceivably still end up financially well-off, despite a corporation’s demise.

Such methods as division of labour, coordination, systematic methods of utilizing capital, subsidiaries, and checks and controls are used by corporations, distinguishing them from the way in which a small business would operate. While most corporations use these aspects to make money for shareholders, CDC’s attempt to use these methods for the broader good of the community (MacLeod, 1986).

As a corporation, the CDC is ultimately under the control of shareholders through the board of directors, not the staff.

The other global intervention tool described by Fontan is the technical resource group for CED. The technical resource group, as described by Fontan, is designed to support the creation of institutions that advocate a global approach. Towards this end, the technical resource group may engage in such activities as research and development, the training of interveners and volunteers, consulting for intervention groups or public administrations, publishing and documentation, and encouraging networking and
consultation between CED practitioners.

The technical resource group may also be involved in assisting specific projects (as opposed to institutions). Activities such as project development, management and administrative support, financial structuring, and the development of sound accounting practices may be undertaken by the technical resource group to assist specific projects (Fontan, 1993).

**Specialized Intervention Tools**

Fontan's list of specialized intervention tools will be listed, though only those tools of specific relevance to CSRB's will be described here.

1. community land trusts
2. community loan fund associations
3. micro-enterprise projects (including peer-assisted lending schemes)
4. community land use corporations
5. neighbourhood boards
6. human resource development initiatives
7. school-business compacts
8. community business incubators
9. early warning systems (with reference to plant closures)

* 10. alternative businesses: An alternative business is defined by Fontan as a business which incorporates into its structure some form of democratic control by its workers. This may take the form of co-operative management; a worker cooperative is a legal business structure, providing each worker-member with one share,
one vote, and an equal voice in company matters. Or an alternative business may have community management, such as with a CDC; in a CDC, the board of directors is ultimately responsible for the corporation, but employees may be provided with direct representation on the board.

* 11. training businesses: A training business is a non-profit organization that combines aspects of vocational training with the operation of a business that produces goods and services to the community. Such projects usually target individuals in unstable situations -- those lacking income, ex-offenders, street youth, or other people who are, or are becoming, marginalized. A Vancouver example of such a project is the Picasso Cafe, a business which provides on-the-job training for youth with unstable backgrounds.

Fontan summarizes:

Just as the private venture can achieve economic objectives related to profitability, so the community economic development enterprise can, as the evaluative literature clearly shows, satisfactorily achieve social and economic objectives when the conditions are right. It therefore seems to be a viable formula, but in applying it, great care must be taken not to reproduce a model or impose from on high a vision of the interventions to be carried out (Fontan, 1993, p. 37).
2.4 Mental Health, Perspectives on the Disabled, and Planning

In this section, the relationship between mental health strategies and perspectives on the disabled will be discussed. As well, developments in mental health and perspectives on the disabled will be related to developments in planning theory. This discussion will present how the thinking on mental health strategies has changed over time, and the changes in other fields that have paralleled such changes. This discussion will lead to the concept of a 'community vision' in mental health.

As discussed in the chapter on mental health policy, for many years the accepted way of dealing with mentally ill people was to place them in institutions. While initially a measure to provide humane treatment, lack of funding caused institutions to become little more than warehouses for the mentally ill, providing social control over a population seen as deviant. The institutional system has also taken away power from those who enter it. They are committed to hospital, made to undergo treatment, then streamed into vocational rehabilitation programs; thus they become consumers of social services, and dependent on professionals. These professionals, whether they be social workers, psychologists, or psychiatrists, set the agenda for rehabilitation of the patient.

John McKnight describes three perspectives governing attitudes towards the disabled: (i) the therapeutic vision, (ii) the advocacy vision, and (iii) the community vision.

The therapeutic vision defines people in terms of needs (as prescribed by professionals), which it is the responsibility of expert systems to meet (CBC Radioworks, 1994). The therapeutic vision has supported the institutional approach to mental health.
Within the field of planning, the dominant planning approach has been the synoptic, or rational comprehensive, model. With this approach, the planner is responsible for (i) setting goals, (ii) identifying alternatives, (iii) evaluating means against ends, and (iv) implementing decisions. Synoptic planning has been criticized for its bias towards central control; in the definition of problems and solutions, in the evaluation of alternatives, and in the implementation of decisions. In terms of its methods and bias towards centralization, this model of planning has much in common with the model of institutional care in mental health.

Concerns about the quality of care in institutions, an increasing awareness of patients' civil rights, and the eagerness of governments to save money spent on institutions led to the movement towards deinstitutionalization of mental patients. After a period in which services to those released were grossly inadequate, community services were set up to provide to this population the things that the institution once did, such as shelter, and medical and vocational services.

The movement towards community care in mental health was based on a realization of patients' civil rights. McKnight, outlining different perspectives on the disabled, describes the advocacy vision, which views the disabled as the bearers of rights which need to be defended.

The advocacy vision with respect to the disabled has parallels with the development of advocacy planning in the realm of planning theory. Rooted in adversarial procedures modelled upon the legal profession, the advocacy planning movement developed in the 1960's. Advocacy planning has generally been applied to defending the
interests of community groups, environmental causes, the poor, and the disenfranchised against the established powers of business and government (Hudson, 1979). The advocacy vision has been responsible for great improvements in the lives of people with disabilities. The advocacy of friends, parents, and concerned professionals was responsible for releasing people from institutions, and getting them into more modestly scaled community services. But recently, this vision has been criticized, particularly on two points. First, what John McKnight has referred to as a ‘defensive wall of helpers’, who in protecting the disabled individual, disconnect her from the larger community. Clients ultimately come to conceive of the community as a hostile, rather than hospitable place. Second, in trying to provide care in the community for the disabled, a new institutional setting has been created, complete with a wall of regulations and legal safeguards making community service systems nearly as inflexible as the institutions that they replaced (CBC Radioworks, 1994).

The Community Vision

McKnight describes society as consisting of two domains: the institutional domain, governed by legal, contractual, and administrative norms --- and the community domain, where people come together for their own purposes. McKnight has written extensively on what he views as the negative impact professionalism has had on society, claiming that through its advance, communities have lost their capacities to care, counsel, and console (CBC Radioworks, 1994).

McKnight’s ideas parallel those of others who criticize the
'service paradigm' on which social services are based. These critics point out that social service has become a big business in society, and that professionals depend on a population of afflicted people as 'consumers' of such services.

As discussed previously, there is now a movement towards decentralization of services, self-help, and alternative vocational programs that place emphasis on greater self-reliance and independence. McKnight describes a community vision, describing a vision of care for the disabled that emphasizes belonging, and connectedness to community.

In the field of planning theory, Friedmann's theory of transactive planning, which calls for a decentralization of planning and institutions, and a process of social learning between planner and client, has some parallels with McKnight's community vision.

Friedmann felt that planning should occur as a result of personal contact between people affected by decisions; through a process of 'social learning' between planner and client would come the relevant issues to be dealt with. At an institutional level, Friedmann saw that transactive planning also should include the development of decentralized planning institutions that assist people to take greater charge of the social processes that dominate their lives (Hudson, 1978). Transactive planning was to emphasize the human dimension so lacking in synoptic planning:

...attention to the personal and spiritual domains of policy impacts, including intangible outcomes beyond functional - instrumental objectives - for example, psycho-spiritual development, enhancement of dignity, and capacity for self-help (Hudson, 1978).
Radical planning is another planning theory to which current movements in mental health have parallels. In discussing this tradition, Gunton describes the criticisms of the synoptic tradition which spurred alternative models. These criticisms, attributed to such authors as Ilich, Grabow, and Heskin, identify policy analysts as:

self-serving professionals who surreptitiously impose their values on society by defining problems in such a way that broad participation is discouraged. Professionals cultivate dependency in order to maintain power and prestige (Gunton, 1981).

Planners in the radical tradition don’t believe that a solution lies in ‘social learning’, which merely perpetuates the privileged position of planners; nor do they believe it lies in reducing the role of government without tackling the problems of private concentration of power, nor relegating planners to the role of referees in an unequal world.

...planners must become social reformers committed to fundamental social change involving redistribution of power and wealth and the rejection of self-serving technology and complexity that gives technocrats power based on their superior knowledge. Planners engaged in social reform must create more decentralized and more self-sufficient social units based on worker ownership and community cooperatives and communes where professional planners are ultimately eliminated (Gunton, 1981).

In the mental health field, the recent movements toward decentralization of services and self-help could be seen to reflect aspects of the transactive planning approach. Consumer/survivor-run businesses, structures based on worker ownership, and which reflect an awareness of the limitations of professionalism, are more reflective of the radical approach to planning.
The following diagram (Figure 2) summarizes the parallels between mental health, planning theory, and perspectives on the disabled discussed in this section.

**Figure 2. Parallels Between Mental Health, Planning Theory and Perspectives on the Disabled**

<table>
<thead>
<tr>
<th>Mental Health Theory</th>
<th>Planning Theory</th>
<th>Perspective on the Disabled (McKnight)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional Care</td>
<td>Rational</td>
<td>Therapeutic Vision</td>
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<tr>
<td></td>
<td>Comprehensive</td>
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<td></td>
<td>Planning</td>
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<tr>
<td>Community Care</td>
<td>Advocacy</td>
<td>Advocacy Vision</td>
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<td></td>
<td>Planning</td>
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<tr>
<td>Self-help/</td>
<td>Radical/</td>
<td>Community Vision</td>
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<tr>
<td>Mutual Aid</td>
<td>Transactive</td>
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<tr>
<td></td>
<td>Planning</td>
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</table>

**Mediating Structures in Society**

Of relevance to consumer/survivor-run businesses is the concept of mediating structures. Sociologist Peter Berger and lutheran pastor Richard Neuhaus wrote *To Empower People: The Role of Mediating Structures in Public Policy*, in 1977. Berger and Neuhaus’s analysis of modern society is that there is currently a 'historically unprecedented' split between public and private life -- between public life dominated by large institutions, and the private life which is of private significance only (CBC Radioworks, 1994). Society’s 'mediating structures' -- the family, neighbours, friends, churches, clubs, local businesses and voluntary associations -- act as a buffer between a vast and bureaucratized
state, and the individual, whose life is usually of private significance only. Berger and Neuhaus believe it is these mediating structures that provide meaning and relevance to the individual’s life. Yet these mediating structures have not been supported by public policy. Berger’s analysis is that the decline of these settings will ultimately lead to totalitarianism -- an all-powerful state acting directly on the individual. To Berger and Neuhaus, support for such mediating structures through public policy is necessary, and would reduce alienation and conserve meaning.

Berger and Neuhaus’ concept of mediating structures is applicable to the provision of social services, currently provided largely by government. In the field of social services, they advocate channelling funds directly to clients of social services, rather than the institutions now providing social services. Clients would then have the opportunity to choose among competing institutions where to spend their voucher, or they could then set up their own mediating structures.

Consumer/Survivor-run businesses could be seen as a form of mediating structure in that they provide an alternative to the provision of services by government and other institutions. Berger and Neuhaus’ study of mediating structures and the necessity of support by public policy of such structures, lends philosophical support for a policy that explicitly addresses fostering the development of, and ongoing support for, Consumer/Survivor-run businesses.
3.0 Consumer/Survivor-Run Businesses

In the 1960's, institutional care for the mentally ill was challenged; later, the community service system was also challenged. Community service has in common with the institutional system the idea that it is possible to create a 'system that cares'. The provision of services has been seen as the only valid use of mental health budgets. Recently, people involved in the field of mental health have come to question whether it is in fact possible to create a caring service system (CBC Radioworks, 1994).

This shift in perception has led to major changes in the field of vocational rehabilitation for the mentally handicapped. One of these changes has been the trend towards consumer/survivor initiatives; these initiatives are not services, but a form of direct action. Such direct action may take the form of advocacy, peer counselling, or self-help. In some cases it takes the form of economic initiatives. The idea of businesses, set up in such a way that people with a psychiatric history control the business, is becoming more widespread. Support for consumer/survivor-run businesses comes on the basis that having control of the business promotes self-reliance, which in turn helps the individuals' self-esteem and mental health.

Support for consumer/survivor-run businesses also comes on the basis of competitive workplaces being shown to better promote an individuals' rehabilitation. A study of programs offered at Ontario's provincial psychiatric hospitals concluded that competitive settings worked better than sheltered settings in the rehabilitation of people with a history of mental illness (cited in Trainor & Tremblay, 1992).
In a competitive business setting, run by consumer/survivors, individuals are no longer clients, but employees and employers. The focus is on these individuals using their talents and skills to create meaningful work; there is little or no input from professional staff.

Such enterprises redefine the relationship of the individual to the employment setting; work becomes meaningful by virtue of the individual’s stake in the enterprise (Trainor et al., 1992). Such businesses have come to be called Consumer/Survivor-Run Businesses, or CSRB’s (Trainor & Tremblay, 1992).

CSRB’s are an attempt by people who have used the mental health system to establish an economic presence which they can control. By doing this, they have been able to turn a psychiatric history into an asset rather than a liability and directly confront a major contradiction in their lives: the contrast between the resources society is willing to put into expensive professional treatment on the one hand, and the marginalization and poverty of everyday life on the other. (Trainor et al., 1992, p. 70)

Five examples of CSRB’s are reviewed below to find answers to the following questions:

1. What are the distinguishing characteristics of this sort of activity? i.e what distinguishes CSRB’s from other types of vocational rehabilitation, and from other types of business organization?
2. What are the opportunities for the development of CSRB’s?
3. What constraints do CSRB’s face?

These questions are to addressed by researching:

(i) existing literature on the various examples of CSRB’s;
(ii) information provided by CSRB’s themselves, i.e. brochures, promotional material.

For the purposes of this thesis, this material will be sufficient to determine the distinguishing characteristics of CSRB’s, and the opportunities and constraints to their development.

The five examples of CSRB’s to be analyzed are:

1. Abel Enterprises
2. A-Way Express Couriers
3. Fresh Start Cleaning and Maintenance
4. Unity Housing
5. Consumer/Survivor Artists Co-operative

3.1 Examples of CSRB’s
3.1.1 Abel Enterprises

Abel Enterprises is a consumer/survivor-run business operating in Simcoe, Ontario. It has also been known as the Haldimand-Norfolk Working Group, after Haldimand and Norfolk counties, the region in which it operates. The oldest of the CSRB’s described in this thesis, Abel Enterprises began in 1983.

The enterprise began as the result of a study, conducted by Haldimand-Norfolk Mental Health Services, into the issues facing people with a serious mental illness in the region. This study, supported by Canada Works funding, found that the most pressing issues were lack of employment, poor living conditions, and desperate financial need. Also found to be of concern was the effect that psychotropic medications had on the mentally ill. From
these issues came the idea for a cooperative business. Emphasis was to be placed on group participation in decision-making; control, and direction of the cooperative was to come from the members themselves (CMHA, 1987).

Starting with a number of men who were consumers of Haldimand-Norfolk Mental Health Services, and with the assistance of a community development worker, Abel Enterprises was born. From the start, the cooperative has been committed to taking advantage of opportunities presented to them by the community; sometimes these opportunities have been small in scale, sometimes large (CMHA, 1987).

As an initial project, the group decided to build a 16-foot canoe, which would then be raffled, providing some capital for the co-operative and publicity from the surrounding community. This project resulted in $700 for the group, and awareness for the project. The group learned, from the Victorian Order of Nurses, that there was a need locally for specialty items for physically handicapped people, such as bath boards, portable wheelchair ramps, walkers, and amputee boards. As several members of the group had wood-working skills, producing these items was a natural project for them. The local community college, Fanshawe College, was approached to provide space for wood-working. This connection with the college subsequently resulted in members being granted access to college courses. Through this arrangement, members have taken courses in carpentry, joining and fitting, first aid, work safety, furniture refinishing, horticulture, commercial application of pesticides and fungicides, commercial fruit trees, small engine repair, cooking for the public, and marketing (CMHA, 1987).
Other work projects were embarked upon. A food concession, run for four consecutive summers, provided employment and developed skills for members. This project was discontinued to focus on other activities. The group also obtained a contract for planting and weeding a woodlot for the local Forestry Station. This was one project that didn’t work for members. The work was strenuous, and there was nowhere to relax and take a break; as a result, members actually went on strike against management. A compromise was reached, whereby the members agreed to finish off the contract, on the condition that no work of this type be undertaken. This situation shows one of the strengths of CSRB’s -- that workers actually have some control over their work environment and decisions that effect them (CMHA, 1987).

The co-operative has struggled to find enough work over the winter months to keep busy. Members have often found themselves shovelling walks after snowfalls. In an attempt to find other winter employment, the cooperative began to create large fibreglass sculptures, to be sold to local businesses and homes during the Christmas season.

Abel Enterprises also assists members who wish to re-enter the regular workforce. By developing vocational skills and the social skills necessary for success in the workplace, Abel may act as a bridge to regular employment for members.

Overall, operating in a relatively small community, Abel Enterprises has been a success. One issue faced by members has been the amount they can earn on top of their disability pension, before it is taxed back. In Ontario, disabled people may earn $160 on top of their disability allowance; above this mark, earnings are taxed
back at 75%. While this policy provides more incentive to work than previous regulations which taxed back earnings more stringently, the limitations placed on the amount of income that can be earned do provide a disincentive towards working more.

Another issue faced by Abel Enterprises has been that of setting aside a portion of profits to be used for expansion of the enterprise. At present, Abel employs many people on a part-time basis; if a substantial amount of working capital could be built up, expansion of the enterprise, full employment, and worker benefits could be developed (CMHA, 1987).

3.1.2 A-Way Express Couriers

A-Way Express Couriers is perhaps the best known example in Canada of a business run with input by consumer/survivors. Using the Toronto transit system, couriers deliver parcels at rates competitive to other courier companies. A-Way, a non-profit enterprise, is run by a Community Development Corporation Board of Directors.

A-Way came into being partly as a result of a 1982 Mayor’s task force that examined issues affecting consumer/survivors. These included the effects of medication, housing, and financial support. The task force was pressed by some mental health professionals to look at the issue of increasing job opportunities for consumer/survivors.

In 1985, the program coordinator of Progress Place, a day treatment centre in Toronto, invited a community development worker who had been involved in the creation of Abel Enterprises to meet with some of the people who were clients at the day treatment
centre. Many of the people at Progress Place had schizophrenia, a
disease that causes these people to be considered more 'high-risk'
and difficult to place in traditional vocational programs. Most
were considered permanently unemployable by mental health staff.
These people also tend to have low self-esteem, poor work records,
and have many health and social assistance related appointments,
causing them to need flexible work schedules.

As has been noted in other examples, most workplaces are not
willing to accommodate the needs of these workers. Schemes such as
supported employment, while worthwhile, tend to place workers in
low-pay, low-status jobs. The fundamental idea behind experiments
such as A-Way and Abel Enterprises is that the workplace should be
made to fit the psychiatrically labelled individual, not the other
way around. Individuals involved in such enterprises gain dignity
by virtue of their work being not just a job, but a venture in
which each individual shares responsibilities and benefits.

The group decided that a worker co-operative model of
organization would allow workers the flexibility they needed. The
group, lacking the technical expertise needed for the initiation of
a worker co-operative, approached a community organizer and a
business-consulting firm. This expanded group continued to meet for
18 months; in the process, it was decided that a light parcel
courier service using the Toronto transit system would be a
workable business and would allow workers the flexibility they
needed. As Brown (1989) notes:

...The decision to develop a worker co-operative resulted
from the inability of existing settings to satisfy the
employment needs of this population. As members of a
co-operative, the psychiatrically-disabled would be able
to develop a long-term employment environment characterized by flexible work hours, tolerance of illness-related absenteeism, hire management who are attuned to their special needs and distribute profit amongst themselves.

(p. 31)

The governing structure of A-Way was fashioned as follows. A Community Development Corporation was established. The non-profit status of the CDC allowed it to benefit from programs and funding agencies prohibited from directly supporting business ventures. The CDC had a Board of Directors, made up of people with experience in mental health, business, and community development. This arrangement allowed A-Way to benefit from the professional expertise of these individuals. A-Way Express Couriers was established as a worker co-operative. Funding was to pass from the CDC to A-Way. At inception, A-Way Express Couriers had its own Board of Directors, completely made up of workers, and elected by the general membership.

A-Way was structured in such a way that decision-making responsibility was to reside initially with a general manager and the Board of Directors of the CDC. Over a five year period, workers were to be trained in co-operative principles, at the end of which decision-making responsibility was to be under full control of the membership.

A-Way Express Couriers began operations in 1987, with $45,000 obtained from public agencies for start-up capital for equipment and development. Funds came from the Ontario Ministry of Health, the Ontario Ministry of Housing, the City of Toronto’s community economic development fund and the Holy Trinity Foundation. Traditional lending agencies had been uninterested in financing a
business owned and operated by ex-psychiatric patients. Within the first year of operations, A-Way needed another $44,000 for operating costs. Overly optimistic revenue forecasts and the decision to buy, rather than rent needed equipment. At this point, Ministry personnel refused to grant the needed funds, unless A-Way changed its operating structure from a worker co-operative to a non-profit organization. After lengthy discussion, the Board of the Community Development Corporation decided to sacrifice the worker co-operative in order to save the business. A-Way currently runs under the direction of the Board of the Community Development Corporation; worker representation on this Board has been increased to 50%. Along with the restructuring of A-Way from a worker co-operative to a non-profit organization, A-Way was also compelled by the Ministry to change from being a competitive business setting to a therapeutic setting. A-Way policies were adapted to adhere to Ministry guidelines, as opposed to competitive business guidelines (Brown, 1989).

Under non-profit management, A-Way has survived and grown. As of January 1993, A-Way employs 35 couriers, 10 office staff, and has 800 customer accounts. A-Way is in the process of expanding its courier staff to 50, and to this end is currently attempting to expand its client base (CSDI, 1994).

3.1.3 Fresh Start Cleaning and Maintenance

In operation since 1989, Fresh Start Cleaning and Maintenance is a community business that provides cleaning services to a number of clients in the Toronto area. Fresh Start has secured 15 cleaning contracts, mostly with social service agencies, and presently
employs 40 consumer/survivors of the mental health system. As with other consumer/survivor-run businesses, most staff work part-time, but some employees have used the opportunity to work full-time and get off social assistance (CSDI, 1994).

In some cases, Fresh Start has obtained contracts with social service providers by agreeing to hire consumers of that particular service.

Fresh Start was developed by consumer/survivors and agency staff as a way of generating work opportunities. At present, Fresh Start is run as a non-profit corporation with its own Board of Directors.

This Board consists of 14 people, 9 of whom are consumer/survivors. Of the 9 consumer/survivors on the Board, 7 are staff representatives; the other two consumer/survivor representatives are recruited from the community. The rest of the Board is made up of people with backgrounds in law, business, and social services. As a result, staff have a high degree of control, but also have the benefit of individuals with professional expertise (Trainor & Tremblay, 1992).

As of 1992, Fresh Start has received funds for its three management staff (an executive director, office administrator, and site supervisor) from CSDI (CSDI, in turn, is funded by the Ontario Ministry of Health); salaries for staff and supplies come from the proceeds of the enterprise (CSDI, 1994).

3.1.4 Unity Housing

Unity Housing began when a number of ex-patients living together in social housing were evicted when one of their number
suffered a relapse. One of those evicted, John Hatfull, decided to get a number of patients together to look after each other. They found a house. Living together, and looking after each other, Hatfull noticed that people were recovering from their mental illnesses (Rich, 1993).

He began to look for others who were interested. With a $67,000 grant from the B.C. Ministry of Health, Unity Housing was formed as a society. Unity Housing now rents 8 houses, offering a safe and nurturing environment for approximately 50 ex-patients.

Besides offering accommodation to people, an intensive self-help program has been initiated. Jobs previously done by professionals and paid care-givers have been taken over by the consumers themselves. A volunteer incentive program has been established, paying volunteers a $100 - $200 honorarium, which acts as a ‘top-up’ to the disability pension that members receive. The following is a list of the volunteer positions that have been developed.

<table>
<thead>
<tr>
<th>Office Management Program Coordinator</th>
<th>Handyman/Driver</th>
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<tbody>
<tr>
<td>Office Management Volunteer Coordinator</td>
<td>Handyman/Painter</td>
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<tr>
<td>Book Keeping</td>
<td>Handyman/Plumber</td>
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<tr>
<td>Reception</td>
<td>Lifeskills Assistants</td>
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<tr>
<td>Public Relations</td>
<td>Individual Outreach</td>
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<td>Community Events Coordinator</td>
<td>Community Group Outreach</td>
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<tr>
<td>Bus Driver</td>
<td>Counselling</td>
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<td>Catering</td>
<td>Advocacy</td>
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<tr>
<td>Janitor</td>
<td>Carpet Cleaner</td>
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Unity Housing is committed to volunteer service delivery, as a key aspect of its program. While what Unity does may not seem to be like other consumer/survivor-run businesses, Unity Housing provides 'employment' for its volunteers by allowing them to develop tangible skills, by paying a $100 - $200 'top-up' on disability pensions, and by giving people some sense of vocation, of purpose (Unity Housing Association, 1994).

3.1.5 Consumer/Survivor Artist Co-operative

The Consumer/Survivor Artist Co-operative was founded in 1993 to identify and support consumer/survivor artists endeavouring to become full-time working artists. Operating on a grant from the B.C. Ministry of Health's Consumer Initiatives Program, the co-operative rented part of a brick heritage building at 1134 Granville St., in Vancouver's west end. After 6 months spent refurbishing and renovating this space, it was opened in January 1994 as the Gallery Gachet (named after Paul Gachet, the homeopathic doctor who treated Vincent Van Gogh) (Wilson, 1994).

The Gallery provides space for consumer/survivors to exhibit their work. Members are also provided with access to computer and video equipment, library, workshops, and a caring atmosphere to pursue their art. In the future, the cooperative hopes to provide studio space (in other buildings), launch a magazine, and have travelling shows which originate at the Gallery Gachet (Wilson, 1994).

The Cooperative intends to run the Gachet as a commercial gallery, funded through the sale of its art. The gallery intends to run 10 shows a year.
Full members of the Cooperative are those who fit the criteria of being dedicated artists, who are consumers within the mental health system, or are survivors of childhood abuse. They must also have developed their art to a level where it can be exhibited. Full members are the decision-makers in the Co-op. Apprentice members, those who meet the admission criteria but have not developed their art to point of exhibition, have some access to Co-op resources, but do not have voting privileges. The Co-op had 30 members when the gallery opened, but is growing as more consumer/survivors hear about the project (Consumer/Survivor’s Artist Co-op, 1994).

As mentioned, the Co-op runs on a $76,000 grant from the B.C. Ministry of Health’s Consumer Initiatives Program, and is sponsored by the West Coast Mental Health Network, an organization that represents and acts as an advocate for consumer/survivors (Wilson, 1994).
3.2 Aspects of CSRB's

3.2.1 Decision-making/organizational structure of CSRB's

A key aspect of CSRB's is that these businesses employ some form of democratic decision-making process, allowing members to have a role in the development and management of the business. This aspect of CSRB's is particularly important in that it addresses the lack of power that consumer/survivors come to expect in their lives. Trainor and Tremblay (1992) recommend that projects adopt organizational models which provide the opportunity for maximum input by consumer/survivors.

The three primary examples (A-Way Express Couriers, Abel Enterprises, and Fresh Start Cleaning and Maintenance) show something of the range of decision-making structures in CSRB’s.

Fresh Start Cleaning and Maintenance, developed in 1989, is organized as a non-profit organization with its own Board of Directors. The Board consists of 14 people, nine of whom are consumer/survivors. Of these nine, seven are elected by non-management staff; two other consumers are recruited from the community. Other individuals, with needed skills in such areas as law, business, and social services have been recruited to fill out the board. This arrangement provides employees with a large degree of control over the business, at the same time providing the business with needed expertise in certain areas (CSDI, 1994).

Two organizations were incorporated when A-Way Express Couriers was developed: Applause Community Development Corporation, a nonprofit community corporation which has a mandate of supporting the development of democratic workplaces for consumers of the mental health system; and A-Way Express Couriers Limited, a worker
cooperative incorporated as a for-profit share capital corporation (Ward & Tremblay, 1988). Each organization had its own Board of Directors. After financial difficulties and subsequent restructuring, the worker cooperative Board of Directors was disbanded; the business then became a non-profit enterprise.

Abel Enterprises is a non-profit work cooperative. While day-to-day decisions are made by the Board of Directors, major decisions are made at the regular membership meetings made every two weeks (Trainor & Tremblay, 1992).

3.2.2 Composition of Staff

Trainor et al. (1992), in reflecting on the experiences of various CSRB’s, make a number of recommendations. Pertaining to staff, they recommend that it is preferable that all employees be consumer/survivors, but that it may be necessary for individuals with experience in the particular business to be employed during an interim stage.

Abel Enterprises has employed staff members (i.e. non-consumers). These people tend to have expertise in areas related to the business’s operation; those employed in the past have included a cabinetmaker, fibreglass worker, and landscape designer. It is felt that these people would be less likely to reinforce a 'patient-client' role with the members of the work group, than individuals with a social service background. Schwartz (1992) has made the same point, observing that disabled people benefit from interaction in what he calls the associational world, where a psychological sense of community exists, as opposed to interaction in the professional/bureaucratic world.
A-Way Express Couriers was initially organized as a worker co-operative. Over a five-year period, decision-making responsibilities were to pass from the Board of Directors of the Community Development Corporation to the members of the co-operative. At the beginning, staff were described as ‘business managers’ whose primary role was to assist with the business’s operations. After restructuring, descriptions of staff positions were changed to ‘Program Coordinator’ and ‘Case Manager’; implying that A-Way had become a therapeutic setting, and that mental health professionals were needed to monitor activities at A-Way (Brown, 1989).

Fresh Start employs about 40 people, most of whom work part-time. Three ‘staff’ are employed to manage the agency; these are an executive director, an office administrator, and a site supervisor.

3.2.3 Source of Funding

Wismer and Pell (1983) describe a number of guiding principles which inform the structure and operation of CED projects; one of these is the ability to secure funds to cover operating and program development costs.

A-Way Express Couriers obtained its initial funding from the Ontario Ministry of Health, the Ontario Ministry of Housing, the City of Toronto’s community economic development fund and the Holy Trinity Foundation. It was projected that the venture would break even by June 1990.

In A-Way’s case, subsequent events have made it clear that ongoing funding was a necessity. As Trainor and Tremblay (1992) note:
CSRB’s have shown they can successfully employ people with serious mental illness. This cannot be done if they are expected to have the same efficiency as other businesses. (p. 70)

A-Way now has ongoing funding through the Ontario Ministry of Health’s Consumer/Survivor Development Initiative (CSDI).

Fresh Start receives funds from the Consumer/Survivor Development Initiative; these cover the costs of its three administrative staff, and the rent of its premises. Revenues from work performed by Fresh Start cover the pay for cleaning staff and supplies.

3.2.4 Market

Abel Enterprises’ main activity is making furniture and specialty products for people with physical disabilities; through networking with various agencies, Abel has developed a market locally in the Simcoe area, as well as in Toronto. Abel has supplied furniture for a number of hostels in Toronto.

When A-Way Express Couriers began operations in 1987, most of its client base came from the public and voluntary sector, including social agencies, provincial ministries, several municipal level departments, several cooperative businesses, and some of Toronto’s major health services. From an initial client base of 15, A-Way had 190 clients within a year. A-Way members quickly realized however, that if the business was to try to break even, they would need to expand its client base. Towards this end, A-Way has been attempting to move into the corporate market. As of January 1993, A-Way had 800 customer accounts, and is making plans to hire more couriers and further expand its client base.
The majority of Fresh Start's contracts come from social service providers; in some cases, Fresh Start has obtained cleaning contracts for social service agencies by agreeing to hire the consumers of that particular service to work at that site.

These results show that CSRB's starting operations should target social service agencies, particularly those that deal with consumer/survivors; at some point, however, expansion beyond the public and voluntary sectors may be necessary to make the business more financially viable. Such expansion may also prove beneficial, as far as helping to counter the stigma associated with consumer/survivors in the larger community.
4.0 Consumer/Survivor-Run Businesses: Lessons to be Learned

From the context chapter, from the experiences described in the examples, and from other research on consumer/survivor-run businesses, issues of relevance to these initiatives will be discussed. These will be divided into constraints and opportunities facing CSRB’s.

4.1 Constraints facing CSRB’s

4.1.1 Bureaucratic Restrictions

A major constraint facing consumer/survivors interested in getting back into the workforce, described in accounts of the experiences of both A-Way Express Couriers and Abel Enterprises, is the bureaucratic restrictions placed upon them. These restrictions affect a number of areas. Principally, limitations placed upon the amount of money that can be earned on top of social assistance payments act as a disincentive to employment for consumer/survivors. Additionally, eligibility for housing and medication benefits is often tied to receipt of social assistance; work can place an actual (or psychological) threat to such necessities for consumer/survivors as medication and shelter.

To assess the impact bureaucratic restrictions have on consumer/survivors who wish to work, it is necessary to present a brief overview of Canada’s income security programs. These programs can be divided into three categories:

1. Programs designed to help the poor:
   - social assistance (this includes welfare and various disability allowances)
   - guaranteed income supplements (these vary from province
People with a mental illness that are receiving supports usually receive social assistance, either welfare or a disability allowance. Currently, British Columbia’s disability allowance provides a single person $771 a month. The procedure for determining who is eligible for a disability allowance is a cause of much frustration for persons with a mental illness, or with other impediments.

In order to be eligible for a disability allowance, a person must be defined as either disabled or permanently unemployable. In the case of someone with a mental illness, they may not fit neatly into these categories. The nature of many mental illnesses is that they are cyclical. A person may be unemployable while they are ill, but capable of employment when their illness is in remission. The concept of a person being ‘permanently unemployable’ does not work well for someone with a cyclical illness (CMHA News, Spring 1993).

And two individuals with the same illness may have different levels of disability as a result of that illness. As an example, we
could consider two people suffering from one of the most common of mental illnesses, manic depression. The first person may do well on medication, and have a network of supports that allows this individual to cope with life's stresses. The second person, also diagnosed with manic depression, may not deal well with medication, or have an adequate network of supports. This second person would be more disabled by her illness than the first, and the label of 'disabled' would be more appropriate in this case (CMHA News, Spring 1993).

People who receive a disability allowance are curtailed in the amount of money they can earn in addition to their basic rate. In B.C., they can earn up to $200 on top of their benefits without deduction; above $200, any income is taxed back at 75% (i.e. they can keep 25%). In Ontario, where most of Canada's experiments with CSRB's exist, a disability allowance pays $792 per month for a single person; they can earn $160 a month on top of this basic amount; after this, they can keep 25% of their earnings.

The situation regarding bureaucratic restrictions has improved in the past few years. In Ontario, at the time of Brown's 1989 analysis, consumer/survivors were only allowed to earn $100 on top of their disability pension; 50% of the next $50 would be taxed back, and 100% of anything earned above that. Clearly, the new regulations are an improvement.

For those who want to continue receiving disability allowances, earning a small top-up may be adequate, but it doesn't provide much incentive to those who want to work more and develop a greater level of independence.

Of greater concern to those working in CSRB's is the
possibility of being cut off from financial assistance altogether if they work more hours. Not only does this place the individual in a difficult position if they suffer a relapse of their illness and need to discontinue working, it also places other benefits at risk. Social housing is often dependent on receipt of social assistance; if the individual is cut off, they may be ineligible for such housing. Inadequate housing is an issue that many psychiatrically disabled have to deal with; frequently, inadequate housing can lead to the relapse of illness. Likewise, medication benefits are often tied to social assistance; without these benefits, individuals may not be able to afford their often costly medications. Without medication, these people will likely end up back in hospital (Brown, 1989).

Addressing this constraint
Brown notes that A-Way workers and social service agency personnel expressed a desire to see more flexible eligibility criteria and access to extended benefits for psychiatrically disabled individuals who are attempting to re-enter the workforce. Furthermore, policies that guaranteed social housing, medication benefits, and immediate social assistance upon job loss would act to support the psychiatrically disabled individual while trying to increase their level of independence.

4.1.2 Attitudes of the General Public Towards Consumer/Survivors

An issue identified in the review of literature regarding vocational rehabilitation is the attitudes that the general public has regarding consumer/survivors (Cochrane et al., 1992). The
important point is that it is not only the effects of psychiatric disabilities that impair functioning in society; the stigma associated with such psychiatric conditions also impairs the functioning of consumer/survivors. Cochrane et al. present the following definition for stigma:

Stigma is any attribute which deeply discredits and lowers the status of an individual once he is known to possess this attribute. (p.10)

The literature reviewed suggests that while the level of public knowledge regarding mental illness has improved, attitudes toward these people remain ‘rather rejecting in nature’. Cochrane et al. (1992) state that employers’ reaction toward this population tend to reflect that of the general public; while employers may not express any reluctance to hire psychiatrically disabled individuals when questioned, in reality, it would seem that they are reluctant to hire these individuals.

Cochrane et al. summarize the problems that face psychiatrically disabled people with regards to seeking employment:

1. Societal attitudes toward the mentally ill, internalized by patients, result in an expectation of rejection, and lowered self-image and self-esteem. Such factors lead to an unwillingness to seek out social contacts;
2. The behavioural symptoms of the disease, which set the individual apart, leads to expectations by both the employer and the ex-patient of an impaired ability to function in a competitive employment;
3. Discrimination by potential employers and co-workers (Cochrane
Despite these findings, the consumer/survivor-run businesses described have generally found acceptance in their communities.

A-Way Express Couriers began by targeting social service agencies, particularly those that dealt with consumer/survivors. While some of these agencies did use A-Way’s service, many did not. Brown (1989) attributes this to certain agencies maintaining a view that consumer/survivors were not really to be trusted, that the level of responsibility involved in the operation of this business was too much. When A-Way began to expand and approached a corporate clientele, they generally found acceptance. Media response to the project has been favourable, including articles in the Globe and Mail and The Financial Post, media outlets generally thought to be ‘conservative’.

One of the attractions of CED interventions to many theorists is that it seems to bridge the old debate of ‘left’ versus ‘right’. While its attraction to those who resonate to ‘left-leaning’ causes is fairly obvious -- its emphasis on social justice for marginalized groups in society -- there is much in CED that also is attractive to those of the ‘right’; the fact that it is presented as a non-governmental intervention; that it emphasizes personal initiative and responsibility; and that it values market-oriented means of capital accumulation, albeit for social purposes. As such, it would seem that CSRB’s have the opportunity to gain mainstream support from the general public, not only from those of one ideological stripe. Furthermore, the experience of the CSRB’s described would seem to suggest that the tendency to stigmatize
consumer/survivors is overcome by the general public’s good will towards alternative projects.

Abel Enterprises operates in a very different setting than A-Way. Where A-Way exists in Metropolitan Toronto, Abel exists in a smaller community (Simcoe, Ontario), in a mainly rural area. One may think that smaller communities might present greater barriers to the development of CSRB’s -- the population of consumer/survivors is smaller, and the perception that small communities would be more likely to stigmatize a population that is ‘different’. Yet, it would appear that Abel Enterprises has been accepted in this community.

Mary Taylor, Abel’s program director, over Abel’s 11-year history has made ongoing efforts to find local people interested in becoming involved in Abel Enterprises -- local businesspersons, church groups, town officials, service groups, and individual citizens. When Abel was first starting up, the leaders of Simcoe’s churches responded by announcing its services from their pulpits. When in need of space for a drop-in centre, the local Presbyterian church provided its basement. Interaction between Abel members and the church congregation also fostered understanding of consumer/survivors and more contact with the community.

Abel Enterprises has also established a relationship with Fanshawe College; the college has, in the past, provided the cooperative with workshop space, and has provided cooperative members with access to college courses. Abel Enterprises has provided products needed by the community. Overall, Abel has had a very positive relationship with the surrounding community.

In ‘Crossing the River’, Schwartz comments on the benefits to
the disabled of living in the community, and having relationships in the community which are not of the contractual type, as in the professional or bureaucratic world, but are of the associational variety of the everyday world. Such relationships will have a beneficial impact not only on the disabled, but also will have a positive effect on the attitudes towards the disabled held by the general public.

While the attitudes of the general public may have an impact on the consumer/survivor who tries to exist in the community, projects such as CSRB's can act to make life in the community easier; these projects have the opportunity to provide a place of belonging, a reason to think of existence as meaningful. In this way, we can see CSRB's truly as a mediating structure, an intermediary between the impersonality of large institutions and the life of the individual.

And in addition, CSRB's also will be more likely to gain the trust of those in the community, than the individual just released from the institution, or the impersonal government-run social service agency.

4.1.3 Attitudes of Mental Health Professionals; The Service Paradigm

A number of barriers to CSRB's arise from the attitudes of mental health professionals themselves.

As Cochrane et al. point out, not all mental health professionals agree that work is a necessary part of the rehabilitative process. Even where there is agreement on the necessity of work, there is often disagreement on where in the
rehabilitative process it should take place. Must the patient obtain work to get well? Or must the patient be well before she can work? This is still a contentious debate (Cochrane et al., 1992).

And, as described in the section on mental health policy, increasingly there is debate upon the limitations of formal services and the potential benefits of non-service approaches, and by extension, the role of mental health professionals. The exclusive focus on service in mental health policy has been termed the service paradigm.

Brown suggests that A-Way Express Couriers was compelled to change the emphasis of the project from that of a competitive business to a therapeutic setting because of prevailing attitudes towards the psychiatrically disabled. In its first year of operation, A-Way having received an initial grant of $45,000, had to ask for an additional $44,000 from the Ministry of Health to continue operations in its first year. This unexpected request was due to an overly optimistic revenue forecast, and spending money to buy walkie-talkie’s for couriers; had the walkie-talkie’s been rented, there would not have been the shortfall. While this shortfall was due to management decisions, Ministry officials demanded that A-Way be converted from a worker cooperative to a non-profit business; in effect, making A-Way members pay for decisions made by the Board of Directors. Brown (1989) argues that the actions of the Ministry were reflective of a prevailing attitude that the psychiatrically disabled have a low capability. Brown states that there was little appreciation of the benefits of self-help, and Ministry of Health staff did not fully understand the nature of the project (Brown, 1989).
It should be noted that these events occurred before the Consumer/Survivor Development Initiative (CSDI) was implemented; the implementation of CSDI would indicate a newfound respect for self-help and mutual aid initiatives. CSDI was enacted by Ontario’s NDP government, elected in the fall of 1990; A-Way’s difficulties with the Ministry of Health occurred during the term of the preceding Liberal government.

Brown cites Ogionwo (1981), who states that the psychiatrically disabled come to view themselves as the people they interact with view them; in particular, mental health professionals. Viewed as dependent, disabled, and inferior by professionals, this population internalizes these views, and are less likely to take risks, or believe in themselves.

The experience of Abel Enterprises has been somewhat different than A-Way’s; Abel has been able to develop independence from professional interference.

A telling example of this regards Abel’s drop-in centre. The drop-in centre associated with Abel Enterprises plays an important role in maintaining a sense of community at the cooperative.

Originally, the drop-in centre was located in the Adult Mental Health Services Clinic of Haldimand - Norfolk. This is the same agency that played a founding role in the development of Abel Enterprises, by assessing the needs of consumer/survivors in Haldimand and Norfolk counties, and by bringing in a community developer to help start up the co-operative. But Abel members using the drop-in centre found the Clinic, with its professional atmosphere, oppressive; it was not a place where members could feel comfortable ‘hanging out’ and talking with each other (CMHA, 1987).
It was decided to move the drop-in centre; drawing upon the connections that Abel built with the local community, the local Presbyterian church agreed to provide its basement for use as a drop-in centre. This arrangement worked until Abel was able to find a location for a drop-in centre in a favourable location in downtown Simcoe; this new location has been paid for by revenues of the cooperative. This situation illustrates how Abel, originally a project of Adult Mental Health Services of Haldimand-Norfolk, has increased its independence.

Abel’s independence from a professional social service approach is further exhibited by its attitude toward staffing; while the cooperative does employ ‘non-consumer’ staff, it makes an effort towards hiring people who have skills relevant to Abel’s business activities -- a designer-cabinetmaker, fibreglass designer, and a landscape designer have been hired to assist the cooperative.

4.1.4 Problems Inherent in Developing New Settings

Brown cites Sarason (1972), who discusses the problems inherent in the development of new settings. Sarason states that agreement upon values and enthusiasm are not enough for the successful development of alternative settings (Brown, 1989). He suggests that other factors need to be taken into consideration. These are:
(a) Differences in the substantive knowledge of participants
(b) Intra- and interpersonal factors
(c) Historical factors, particularly the dynamics of the existing system
Failure to take these factors into consideration, Sarason suggests, will lead the creators of alternative settings to underestimate the impediments and difficulties that inevitably will be encountered. Brown (1989), in her analysis of A-Way Express Couriers, develops these points with regard to A-Way’s development.

Differences in the substantive knowledge of participants

As an experiment unique in North America, those participating in A-Way’s development didn’t have an example that they could follow. Three groups of actors were involved in A-Way’s development: mental-health professionals, business consultants, and the consumer/survivor clients themselves.

Brown notes that mental-health professionals involved in A-Way were accustomed to a professional environment where clients were assigned to sheltered workshops. These professionals had little experience in implementing more competitive settings for the psychiatrically disabled. In the terms used in the context chapter of this thesis, these professionals were guided by what McKnight would call a therapeutic vision.

The business consultants, while having had substantial experience in developing co-operative businesses, had little experience working with psychiatric patients.

The clients themselves were engaged in trying to learn about the operation of co-operative businesses. According to Brown, they were making progress in this area (Brown, 1989). Members of the Board of the Community Development Corporation, were less inclined to learn about co-operative entrepreneurship; the Board had become increasingly dominated by social service professionals whose
inclinations were also toward a therapeutic vision.

The consumer/survivor clients themselves could be said to be operating with a community vision, where finding a place where one belongs and is connected to a community is of greater importance to well-being than dealing with the limitations imposed by their illness and experiences.

Intra- and Interpersonal factors

Brown (1989) discusses how the differing motives of the various actors involved affect the development of alternative settings. Mental health professionals, whose articulated motive would be helping their clients, likely also have other motives, namely career advancement. Behaviour that is questioning of the inadequacies of the existing mental health system will likely have professional ramifications (Brown, 1989).

Community developers involved in development of alternative settings have their own perspectives and ideologies. Concerned primarily with social change, they may not be sensitive to the limitations placed on mental health professionals, and may have unrealistic expectations with regards to what can be accomplished (Brown, 1989).

Consumer/survivors may perceive themselves to be powerless to take control of their situation. Accustomed to social assistance, and dependent upon agency staff, the development of alternative settings that better suit their needs may seem an unrealistic dream.

Brown, in her study of A-Way Express Couriers, asserts that the failure to acknowledge the different perspectives of those
involved had an negative effect on the project’s course.

**Historical factors**

Another problem inherent to the development of alternative settings may be termed 'historical factors' (Sarason, 1972). Though developed in response to the perceived inadequacies of existing settings, the alternative setting becomes a part of the existing system that it critiques. The alternative setting will often retain some of the history, tradition, and philosophy of more established settings.

Brown notes that A-Way was conceived as a radical alternative to the existing vocational rehabilitation system. A-Way was structured so as to provide the independence and flexibility in working hours that the consumer/survivor members felt they needed. Organized as a worker co-operative, full control of the enterprise was to pass to the members over a five-year period.

A-Way’s existence in a mental health system characterized by a bias of client incompetence had implications on its development. Also of relevance was the fact that A-Way was forced to compete for funds with more established programs. When financial difficulties arose, funding agencies assumed that the cause was the slowness of members, and the awkwardness of the cooperative structure. Members of the board of the Community Development Corporation decided to jettison the worker co-operative structure in favour of a non-profit business structure. While members now make up half the board membership, and a flexible and sensitive working environment has been maintained, the original worker cooperative structure has been abandoned.
4.1.5 Difficulties Inherent in the Operation of Cooperatives

This constraint relates to obstacles to the effective functioning of democratic workplaces, and in particular, obstacles relating to the involvement of consumer/survivors in such workplaces.

Gamson and Levin (1984) identify three common organizational obstacles to the effective functioning of democratically managed workplaces. These are (i) the lack of a common culture, or social contract, that creates a widely accepted set of values which guide behaviour in the enterprise; (ii) an inappropriate mixture of skills for the needs of the enterprise; and (iii) a lack of democratic norms for decision-making.

The first obstacle relates to the observation that most people are attracted to democratic workplaces because of an aversion to the culture of the traditional workplace, with its elements of authoritarianism and control (Gamson & Levin, 1984). While they may be in agreement regarding what these workplaces are not, they may have different ideas as to what they are. Gamson and Levin assert that these workplaces need to come to a consensus regarding explicit ways of dealing with destructive members, and regarding the positive values of the enterprise. Gamson and Levin call for two strategies: a formal code of social statutes describing the rights and obligations of workers; and second, a special emphasis on the training of workers.

The second obstacle, an inappropriate mixture of skills for the needs of the enterprise, will likely be particularly applicable to consumer/survivors. Many consumer/survivors have had to drop out of the workforce because of illness factors. Obviously, a
particular emphasis will have to be placed on training.

Ward and Tremblay (1988) describe an intensive training program for members of A-Way Express Couriers, when that business first opened.

The third obstacle mentioned by Gamson and Levin is the lack of democratic norms for decision-making. They identify areas of conflict regarding the exercise of authority, obtaining accountability from members, the productive use of conflict, and the productive use of meetings.

While many people show enthusiasm for the concept of participatory structures, few in our society have experience with this concept. At best, we may be familiar with representative forms of democracy. Consumer/survivors in particular, may be accustomed to having decisions made for them by medical or social service personnel.

Yet, from the CSRB’s researched in this thesis, it appears that with some assistance, consumer/survivors have been able to function in a worker cooperative.

Brown (1989) interviewed members of A-Way to try to ascertain how well they functioned in a worker cooperative setting. The members she interviewed related the high level of worker participation in the cooperative’s development. She also found that member participation and education was important to those interviewed. Early in A-Way’s development, members enlisted the services of a business-consulting firm experienced in developing worker cooperatives. This firm provided workers with information about co-operative entrepreneurship and organizational procedures (Brown, 1989).
An issue brought up by critics of worker cooperatives is that the decision making process is too lengthy; and so not conducive to the need for quick decisions made in response to crises or opportunities (Gamson & Levin, 1984). Gamson and Levin point out that this issue reflects a misunderstanding of the scope of democratic decision making: typically the membership is consulted on issues of broad policy, rather than day-to-day management.

4.1.6 The Drift Towards Professionalism

Related to the problems inherent in developing new settings described in the previous section, is what Schwartz calls the drift towards professionalism.

The differences in substantive knowledge and in motives of the various participants, and the institutional context the alternative settings land into, will tend to draw the new setting towards established ways of operating. Our society’s bias towards professionalism is largely unconscious, and pervades our conceptions about how we should help others. Such a bias will have an impact upon new settings, particularly if they are experiencing the conflicts described in the previous section. Without an awareness of this trend, this pervasive belief system will come to displace alternative and community practices (Schwartz, 1992).

When A-Way Express Couriers ran into financial difficulties in its first year of operation, the response from Board members was to suspend the plan to develop a worker co-operative (admittedly at government pressure to do so), and develop a somewhat more commonplace model, a non-profit community business. While still a worthwhile venture, one that provides employment and a level of
stability to its members that they would not otherwise have had, the drift towards professionalism that Schwartz describes is evident.

Abel Enterprises experience has been different, likely for a number of reasons -- its small scale nature (it didn’t get involved in the level of capital outlay that A-Way did, and so did not get into trouble financially), and its strong connections to the local community.

In the following quote, Schwartz describes the need for vigilance regarding the tendency towards drift.

the task of people trying to do this work, then, is not only to rediscover community, but to find ways to counter the tendency to drift towards professionalization.... to do otherwise is to lose one’s way (Schwartz, 1992)

Schwartz lists a number of ways to deal with the drift towards professionalism.

He suggests that projects should not try to survive in isolation; networking between projects is a good way to foster mutual support and avoiding drift. Networking may occur on a formal or informal level. Examples of formal support networks are the Provincial Consumer/Survivor Business Council (Ontario) and the Toronto Community Economic Development Network.

Leadership and educational development programs that provide skills to consumer/survivors, allowing them to take on greater responsibilities, will also counter the tendency toward drift.

Project review mechanisms may also play a role, provided that they do not focus solely on whether or not the project is making money. As Trainor and Tremblay point out, CSRB’s cannot be expected
to have the same economic efficiency as other businesses.

A funding structure, such as Ontario’s Consumer/Survivor Development Initiative, may act as an intermediary between CSRB’s and the large bureaucracies of government; Schwartz asserts that such structures might be necessary to cut down the amount of paperwork and bureaucratic procedures that small, informal settings have to deal with (Schwartz, 1992). Schwartz also proposes that funding approaches be structured in such a way that the funding body cannot exert pressure on the alternative setting such that a ‘drift towards professionalism’ occurs. Such pressure was seen in the example of A-Way Express Couriers.

Finally, if a project has drifted so far from its original purpose that it cannot be turned around, de-funding may be necessary (Schwartz, 1992).

Ontario’s Consumer/Survivor Development Initiative (CSDI) is an example of a funding approach that minimizes pressure for professionalization. CSDI is an initiative that has a mandate for funding consumer/survivor-driven projects, and requires that projects, in order that they be eligible for funding, have a democratic, membership-driven process in place.
4.2 Opportunities for CSRB’s - Why have the examples studied succeeded?

Despite the constraints discussed, our primary examples (A-Way, Abel Enterprises, and Fresh Start) have survived over a length of time. The research suggests the following characteristics of these projects (some inherent to the model itself) have contributed to their survival.

4.2.1 Human Factors

Because CSRB’s have demonstrated the following benefits, consumer/survivors are motivated to develop, participate in, and support CSRB’s.

1. **Flexible work schedules:** Tolerance of medically-related absences, part-time work schedules (generally preferred by consumer/survivors), and a guarantee that employment will be available should a worker’s illness force him or her to return to hospital for a period of time, are important characteristics of CSRB’s.

2. **Supportive management strategies** can assist consumer/survivors through an understanding the nature of their illnesses, and offering non-judgemental support.

3. Part-time work offers the opportunity to **supplement social assistance payments**.

3. Involvement with a CSRB, especially given the sharing of control over decisions, will increase **social interaction** between consumer/survivors.

4. Often possessing checkered histories in the workforce, interspersed with periods of unemployment and hospitalization,
CSRB’s offer consumer/survivors the opportunity to create a work history for themselves.

5. Involvement with CSRB’s can provide consumer/survivors with skills that will assist in subsequent employment, should the individual wish to move on to a greater level of responsibility.

6. Involvement with a CSRB will assist consumer/survivors to structure their time. The enjoyment of leisure time is often dependent on a sense of accomplishment in other areas of life (Cochrane et al., 1990).

7. The previous benefits mentioned will likely result in an increase in self-esteem which will be beneficial for the individuals’ life in general.

(from Brown, 1989)

Support for the assertion that involvement with CSRB’s will have a positive impact on consumer/survivors is given by a study on recidivism (Trainor & Tremblay, 1992). The study surveyed consumer/survivors involved in five CSRB’s. These individuals were asked to fill out a questionnaire, eliciting information regarding five areas of service use: (i) number of days spent in hospital, (ii) number of admissions to hospital, (iii) visits to out-patient services, (iv) contacts to crisis services, and (v) visits to private physicians. Those surveyed were asked to provide this information for equal periods, before involvement, and after joining the CSRB. It should be noted that recall bias is implicit in this method. The hypothesis was that CSRB involvement would have a positive effect on the three areas of service use which would represent the most serious problems in a person’s life. The
findings of the survey supported the hypothesis: for number of days in hospital, number of admissions to hospital, and crisis contacts, there was a statistically significant decrease. Private doctor visits and hospital out-patient services, both indicative of maintenance support, also decreased, though not enough to be statistically significant (Trainor & Tremblay, 1992).

These findings strengthen the notion that consumer/survivors will be motivated to participate in CSRB’s. As well, CSRB’s are likely to gain support from the general community; people interested in making a contribution to their community will likely see CSRB’s as worthwhile. Such community support has been particularly beneficial in the example of Abel Enterprises, which has gained business opportunities, and various forms of assistance from its community, that has contributed greatly to its success.

4.2.2 Economic Factors

The recidivism study quoted in the previous section suggests that CSRB’s will also have a positive impact economically, if consumer/survivors involved with CSRB’s make less use of traditional medical and social services. Also, these structures operate with fewer professional staff than other vocational programs, and so are less costly in this regard.

Because CSRB’s are efficient from a community welfare point of view, they are attractive to government program funders, and attractive to investors interested in worthwhile community projects.

4.2.3 Broad Community Support

To varying degrees, the examples studied have generated broad
community support, beyond the service providers who normally are the only support available for consumer/survivors. A-Way's attempts to move beyond its social service clientele and into Toronto's corporate world is an example of a CSRB broadening its base of support. Abel Enterprises' efforts -- targeting local businesses, church congregations, the local community college -- generated awareness in the community, provided the enterprise with various supports in its development, and generated economic opportunities for the enterprise. Abel's efforts would seem to exemplify Schwartz's approach, which aims to re-awaken a community's capacity to "care, console, correct, and counsel", functions that have been taken over by society's institutions (CBC Radioworks, 1994).

CSRB's have demonstrated the ability to generate broad community support; this has contributed to the success of the examples studied. This ability to generate broad community support also contributes to the viability of CSRB's. Projects capable of generating broad community support will have a much better chance to succeed, and once again will be more attractive to program funders and investors.

4.2.4 Meaningfulness

One of the most important characteristics that make CSRB's worthwhile is that they provide an opportunity for more meaningful lives for consumer/survivors. This is accomplished in a number of ways.

CSRB's offer the consumer/survivor the opportunity to engage in meaningful and productive work; meaningful, through having some level of control over the enterprise; and productive, as the CSRB
provides a good or service needed by the community.

Through having a role in the management of the enterprise, either through shared ownership or through some form of democratic control over decisions made, consumer/survivors can assist in the creation of a work environment that suits their needs.

CSRB’s, in that they address not only efficiency and therapeutic benefits, but also meaning and dignity, are likely to attract support from consumer/survivors.

4.3 Large-Scale Political and Economic Factors

Another aspect which contributes to the viability of CSRB’s is the particular political and economic climate of these times.

A troubled economy, where unemployment for all workers is high, will make it especially difficult for the psychiatrically disabled worker to find competitive employment. One study from Britain, conducted by a regional psychiatric hospital, showed that rising unemployment rates had the effect of decreasing the numbers of mentally ill finding competitive employment. This study asserted that an unemployment rate of greater than 6% made the placement of psychiatrically disabled workers nearly impossible (Morgan and Cheadle, 1975).

Furthermore, economic downturns will tend to have an effect on vocational programs that provide employment for psychiatrically disabled individuals (Church and Pakula, 1984; Olshansky, 1968). Concerns regarding public debt will likely cause pressures on funding for such programs.

This situation, which includes concern about public funding of programs and a tight labour market, might make alternative settings
such as CSRB’s more attractive.

4.4 Rationale for a Funding Structure

As discussed previously, CSRB’s provide benefits to consumer/survivors. Furthermore, political and economic factors favour the establishment of alternative settings. And, as we have found from the analysis of examples, CSRB’s are likely to need ongoing funding and support. More experiments with CSRB’s will provide more knowledge regarding opportunities and constraints to their development.

Schwartz, in describing the needs of alternative settings, calls for an intermediary structure mediating between small, informal settings, and large government bureaucracies; in this way, the smaller setting is not overwhelmed with procedures and paperwork necessary to satisfy its funding agency (Schwartz, 1992).

In developing CSRB’s, consumer/survivors will likely have to deal not only with a lack of capital, but also with some of the other constraints mentioned, such as bureaucratic restrictions and a history of dependency upon professionalized services. A supportive structure may be the most appropriate way of supporting the development and maintenance of CSRB’s (Trainor & Tremblay, 1992). What would such a structure for CSRB’s look like? This question will be discussed in Chapter 5.
5.0 Supporting CSRB’s

Consumer/survivor-run businesses, as an alternative to existing vocational rehabilitation programs for the mentally ill, deserve to be given more attention; to develop more experiments of this nature, some supports will be needed. This could be achieved through a provincial strategy, that makes the development of CSRB’s an explicit intention of policy (Trainor & Tremblay, 1992).

Consumer/Survivor Development Initiative

Ontario is leading the way, in the regard of making CSRB’s an explicit intention of policy. Ontario’s Consumer/Survivor Development Initiative (CSDI) has resulted in the development of 34 consumer/survivor initiatives.

The Consumer/Survivor Development Initiative (CSDI) is funded by the Community Mental Health Branch of the Ontario Ministry of Health. It was enacted in 1991 to provide direct funding to consumer/survivor-run initiatives. An initial grant of $3.1 Million was provided for CSDI; the Community Mental Health Branch then issued a call for proposals from various consumer/survivor groups, District Health Councils, and community mental health agencies. From 266 proposals received, 42 were selected for funding.

At the beginning, about half of the selected projects were aligned with community mental health agencies. However, CSDI came to the point of view that in order for consumer/survivor organizations to break away from the professional service model (the ‘service paradigm’), it would be best for projects to be independent of traditional service agencies. Most projects initially sponsored by community mental health agencies are now
free-standing, and are being incorporated as non-profit organizations.

Initiatives in four areas have been promoted: mutual support, advocacy, knowledge production and skills training, and economic development. Of the total of 34 initiatives, seven have an economic development focus. These include several in operation or in the planning stages before CSDI was enacted, but which are now assisted by CSDI funding.

CSDI is a response to the limitations of the traditional mental health service system (CSDI, 1994). Consumer/survivors had found that the traditional service system had not been an answer to finding self-realization; while funds were being given to service agencies and to expensive professional services, consumers often found themselves confined to lives of poverty and alienation. The following quote, from CSDI’s literature, describes something of CSDI’s rationale and philosophy:

CSDI is unique in that it has made it possible to place real, substantial funding in the hands of consumer/survivor groups. While there has been much rhetoric about the importance of self-help and of consumer/survivor involvement in the mental health system, through CSDI the government of Ontario has made available the funding and resources to actually demonstrate the importance.. (CSDI, 1994, p.1)

In 1992, CSDI received a three-year grant from Treasury Board of $3.5 million a year; those funds currently support the 34 consumer/survivor initiatives.

The CSDI is one example of a support strategy for CSRB’s. Based on the literature reviewed in this thesis, and the examples of CSRB’s described, what elements should a provincial strategy encompass?
5.1 Elements of a provincial strategy supporting CSRB’s

5.1.1 Funding for CSRB’s

Should CED ventures obtain funds from government? Wismer and Pell (1983), in describing aspects of community-based economic development, advocate that CED projects be able to raise the funds necessary for their operation. Part of the allure of alternative settings for the disabled is that they provide an alternative form of service to the disabled that involves less public funding than traditional services.

At a practical level, however, funding from government agencies has been needed by all the examples of CSRB’s discussed in order to survive. CSRB’s have shown that they can successfully employ people with a history of serious mental illness. As such, they can’t be expected to have the same efficiency as other businesses. Ongoing subsidies will likely be necessary (Trainor & Tremblay, 1992).

There is, however, an example of an alternative vocational setting that has survived without government funding. All-Win Workshops in Richmond has operated since 1991; it was founded by Dr. Cyril Brown and his wife, Jan. Brown, a retired doctor and paraplegic, wanted to provide a setting where disabled people could perform meaningful work. All-Win presently is in the business of recycling used printer cartridges, by re-inking and reloading them. Its corporate clients include VanCity Savings Credit Union and Burnaby General Hospital. Run as a non-profit society and registered charity, All-Win provides employment to people with a range of disabilities - from multiple sclerosis to schizophrenia. Brown wants All-Win to be a working model for other groups
interested in independent, self-supporting workshops run by and for people with disabilities.

5.1.2 Aspects of CSRB’s to be encouraged

While control of their development should be in the hands of consumer/survivors themselves, Trainor and Tremblay (1992) recommend that certain key aspects are vital to the impact that CSRB’s can have on this population.

5.1.2.1 Flexibility in working hours

Flexibility in working hours, allowing workers to work part-time, take time off for medical reasons, or appointments is a key aspect of the examples of CSRB’s described.

5.1.2.2 The adoption of organizational models which guarantee control to consumer/survivors

Trainor and Tremblay recommend that all employees be consumer/survivors; for an interim phase, however, it may be necessary to employ individuals with expertise in the particular business.

5.1.2.3 Ensure that projects adopt organizational models which emphasize the involvement of employees in decision making

Projects funded through CSDI must have a democratic, membership-driven process in place. Projects must have a Board of Directors, steering committee or some other governing structure which is elected by, and reflects the membership.
5.1.2.4 Support of Networking Between CSRB's

Providing technical assistance to consumer/survivors could also provide a setting for networking between individuals and groups intending to develop their own businesses.

In Ontario, the Provincial Consumer/Survivor Business Council, supports networking between CSRB’s; the Toronto Community Economic Development Network, and the Women’s Community Economic Development Network bring together CED efforts.

These aspects -- flexibility in working hours, adoption of organizational models guaranteeing control to consumer/survivors, emphasis on employee-involvement, and networking -- may be maintained in CSRB’s by the supportive structure by only funding those projects which adhere to these aspects.

5.1.3 Technical Support

Another of Trainor and Tremblay’s recommendations is that CSRB’s be offered technical support. A model for this may come from Vancouver’s Downtown Eastside Economic Development Society (DEEDS), which closed its doors in 1993 due to discontinuation of federal funding. DEEDS was closed despite its success in acting as an business incubator, employing an estimated 250 people (Globe and Mail, Apr. 9, 1991). DEEDS had 11 spaces at its location where fledgling businesses could get started. It also provided business counselling, photocopier and fax machine, and a small library of self-help business books. The business counsellor assisted clients by helping them set out a business plan, identify markets, and find funding sources and other resources. DEEDS also provided its services to businesses in the community for a $15 annual
DEEDS also had started a PAL (peer-assisted loan) program. With this approach, based on Third-World lending circles, a small group of DEEDS members meet regularly to offer mutual support, guidance, and monitoring of small loans in the $500 - $1000 range. Like other PAL programs, this program is designed to provide capital to poor people who lack collateral and equity, and don’t qualify for loans from established financial institutions.

A support structure for CSRB’s, as well as providing funding, might also provide such technical services to assist consumer/survivor-run businesses. Business counselling, and the provision of computer, fax, and photocopier service could assist such businesses in getting off the ground. Such a service could also support networking between CSRB’s.

5.1.4 Economic disincentives to employment

A provincial strategy to support CSRB’s would also have to address the issue of economic disincentive to employment. Currently, people can only earn $250 on top of their assistance; any amount earned above that is taxed back. Making these allowances more generous would help; as would guarantees for disabled people that their access to social housing and medication benefits would not be jeopardized by increasing their involvement in employment.

5.1.4.1 Analysis of Expenditures

At a policy level, there has been much discussion of allocation of funds away from institutional settings, and towards community service settings; likewise, policy documents put out by
provincial governments discuss the need for self-help, mutual aid and advocacy initiatives. An analysis of expenditures reveals a lack of commitment to community services, in comparison to the funds still provided to institutional settings. An analysis of Ontario’s provincial mental health expenditures, conducted for the 1989 - 1990 fiscal year, shows that only 16.5% of provincial mental health funding went to community mental health services. And as for funds allocated to self-help initiatives, these are tiny in comparison to both institutional and community settings (Lurie & Trainor, 1992). In Ontario, $3.2 million was spent on the non-service sector, representing about 0.2% of total mental health expenditures.

An issue brought up by mental health workers is competition for funds - will funding of more self-help projects, particularly CED projects, result in fewer funds for established programs, especially those in the vocational rehabilitation field?

Mutual aid and self-help represent a tiny percentage of the total amount spent on mental health. The small-scale nature of projects in this sector means that they would not tend to be a threat to larger, traditional programs. And given their potential for greater cost-effectiveness, funds directed to this sector could be a wiser investment.
The literature reviewed makes clear that while existing forms of vocational rehabilitation are appropriate in many cases, they also have limitations. These limitations include dependency on professionals and the fact that work is often of a menial nature.

Community economic development is an economic model particularly applicable to the most marginalized groups in society. Self-help is a movement in mental health that emphasizes the importance of mutual aid, particularly as an alternative to professionalized services that reinforce patterns of dependency. Taking elements from both community economic development and self-help, consumer/survivor-run businesses, provide meaningful work to consumer/survivors by virtue of their having a role in the development and management of the enterprise.

Based on a review of relevant literature, and a review of five examples of consumer/survivor-run businesses, the following constraints facing these projects can be determined: (i) bureaucratic restrictions, with respect to how much consumer/survivors can earn above their disability pensions; (ii) attitudes of the general public towards consumer/survivors, specifically the stigma attached to mental illness; (iii) the attitudes of mental health professionals, specifically what has been described as the service paradigm; (iv) problems inherent to the development of alternative settings, and (v) the drift towards professionalism that many alternative settings experience.

From the review of literature and the examples of CSRB’s, the following opportunities were apparent: (i) the benefits that CSRB’s present to consumer/survivors; (ii) economic factors that call into
question the viability of existing forms of vocational rehabilitation, and make the development of alternatives an option; (iii) a support structure, which through funding, and technical assistance, will act as a catalyst for the development of CSRB’s.

An outline of such a support structure is developed, including the following aspects: (i) ongoing funding for CSRB’s; (ii) the encouragement of flexibility in working hours, democratic decision-making, consumer/survivor control, and networking; (iii) technical support, and (iv) addressing the issue of economic disincentives to work. A further aspect that could be addressed by such a supportive structure would be an analysis of government expenditures on mental health, determining what the levels of funding are for the institutional, community, and mutual aid/self-help sectors, and whether the mutual aid/self-help sector is adequately funded.

A philosophical background for the development of CSRB’s is presented: in mental health, we can see a transition from a therapeutic vision, to an advocacy vision, and now to a community vision. Such a community vision for mental health should not be romanticized; alternative settings will have their drawbacks. But, as Schwartz (1992) points out, it is in such settings that people will find independence and acceptance. Gandhi’s admonition that we should ‘beware of thinking of systems so perfect that nobody will have to be good’, seems to be relevant in this case; in CSRB’s, consumer/survivors are not creating settings that are perfect, but settings that will allow the inherent good in people and in communities to show itself.
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