SELF-HELP IN MENTAL HEALTH:
OPERATIONALIZING A CONCEPTUAL MODEL

By

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ABSTRACT

This study aims to examine the self-help mode of care giving in mental health, especially the manner in which the working self-help model differs from its theoretical counterpart. For this purpose, a conceptual model of operationalizing self-help has been developed. This model traces the process of establishing self-help groups, from theory to practice, and incorporates the barriers such groups may face in becoming a viable alternative to the current health care system. These include the effects of public policy, the professional and the community. The results of this study, based on empirical evidence collected in Vancouver, B.C., suggest that at least to some extent, this model does accurately depict the processes involved with the operationalization of a self-help model, as well as the factors impinging on a full realization of self-help goals. Both public policy and professional influences serve to act as direct constraints to the full implementation of self-help. The community does not share this characteristic, partially due to favourable zoning policy in Vancouver. In spite of these barriers, self-help groups are able to function as an effective alternative. However, it is demonstrated that some of their original goals have not been fulfilled. In conclusion, a theoretical perspective, in the context of Marx and Weber, is outlined, thereby suggesting some of the broader issues associated with implementing a self-help model.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td></td>
<td>ii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td></td>
<td>v</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td></td>
<td>vi</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td></td>
<td>vii</td>
</tr>
<tr>
<td><strong>CHAPTER ONE</strong></td>
<td>Introduction.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Distance and Locational Considerations.</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>The Community Mental Health Movement: Deinstitutionalization.</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Community Opposition to Community Based Mental Health Facilities.</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Spatial and Social Segregation of The Mentally Ill.</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Neighbourhoods as Supportive Networks</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Self-Help: Formalized Support Networks</td>
<td>18</td>
</tr>
<tr>
<td><strong>CHAPTER TWO</strong></td>
<td>Toward an Operational Model of Implementing a Self-Help Mode of Mental Health Care.</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Public Policy and the State</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>The Professional and the Professional Ethic</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>The Community</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Secondary Links</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Outcome</td>
<td>54</td>
</tr>
<tr>
<td><strong>CHAPTER THREE</strong></td>
<td>Research Design.</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>Research Design</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>Sample Selection</td>
<td>66</td>
</tr>
</tbody>
</table>
Research Methods .................................................. 69
Interviews (I) ......................................................... 69
Interviews (II) ......................................................... 71
Questionnaire .......................................................... 72
Documentary Sources ................................................. 74
Development Permit Files ............................................ 74
Summary ............................................................... 75

CHAPTER FOUR  The Role of Professionals, Public
Policy, and the Community in Self-Help:
A Vancouver Case Study ............................................. 77
Self-Help versus the Medical Professional ..................... 78
Public Policy and Self-Help Funding ............................... 90
Self-Help in the Community ......................................... 96
Summary .................................................................... 105

CHAPTER FIVE  Mental Health Self-Help:
Image and Outcome ................................................... 107
Assessing Self-Help in Practice ..................................... 108
Assessing Self-Help in Theory ....................................... 130
Conclusion .................................................................. 141

BIBLIOGRAPHY .......................................................... 143

APPENDIX I  Mental Patients' Declaration
of Principles ............................................................ 152

APPENDIX II  Bill of Rights for Psychiatric
Inmates in Canada ..................................................... 156

APPENDIX III  Interview (I) Skeletal Questions ................ 159

APPENDIX IV  Mental Patients' Association
Questionnaire ............................................................ 162
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Application of Data Types to Model.</td>
<td>76</td>
</tr>
<tr>
<td>II</td>
<td>Sources of Information About the Mental Patients' Association.</td>
<td>83</td>
</tr>
<tr>
<td>III</td>
<td>Reasons for Initial Visits to the Mental Patients' Association.</td>
<td>84</td>
</tr>
<tr>
<td>IV</td>
<td>User-Assessed Attributes of the Mental Patients' Association.</td>
<td>112</td>
</tr>
<tr>
<td>V</td>
<td>Perceived Effectiveness of the Mental Patients' Association.</td>
<td>119</td>
</tr>
<tr>
<td>VI</td>
<td>Significant Attributes of the Mental Patients' Association, as Ranked by Members</td>
<td>121</td>
</tr>
<tr>
<td>VII</td>
<td>Positive Attributes of the Mental Patients' Association, as Ranked by Members</td>
<td>122</td>
</tr>
<tr>
<td>VIII</td>
<td>Negative Attributes of the Mental Patients' Association, as Ranked by Members</td>
<td>124</td>
</tr>
<tr>
<td>Figure</td>
<td>Description</td>
<td>Page</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>1</td>
<td>Conceptual Model of the Operationalization of Self-Help</td>
<td>29</td>
</tr>
<tr>
<td>2</td>
<td>Geographical Distribution of Mental Health Boarding Homes in Vancouver</td>
<td>102</td>
</tr>
</tbody>
</table>
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CHAPTER ONE

INTRODUCTION

Geographers, planners and mental health care professionals have for some time explored the community components of mental health, with respect to treatment, maintenance and community-associated causes of mental ill health. In fact, long before the emergence of mental health as a concern for academics and clinicians, the 'community' for those suffering from mental illness has been distinctly delineated. At times the mentally ill have been invited to be a part of the same communities as those shared by their kin and peers, but more often they have been segregated to form impenetrable communities of their own. Hence, the domain of mental illness has repeatedly been divorced from the environment in which day to day living takes place. Similarly, academic study of mental illness can no longer be relegated to behind the analyst's couch or restricted to the asylum. For the asylum is just that - a safe place of refuge far removed from the environment which is so crucial in our understanding of all facets of mental health and mental illness.

The notion of 'community' for the mentally ill is a constantly changing one, reflecting psychiatric philosophies and general societal trends. This history can be traced at least as far back as the 5th century B.C., when the mentally ill were cared for in the community, often by family or friends. They were not concealed, but they were often ridiculed, the
objects of amusement of the 'saner' sectors of the population. These ideas had changed in Medieval Europe, where the transition to segregated communities for the mentally ill was initiated. This trend grew quite widespread by the end of the 16th century, which started simply by excluding the mentally ill from towns and villages, leaving them to wander in uninhabited areas. The trend toward institutionalization was realized, in its early stages, as leper houses were converted to homes for the poor, derelict, or other 'insane' sectors of the community. Alternatively, they were placed on the infamous mad ships with voyaging merchants to be dropped off in barren and uninhabited lands on the ships' routes. Consequently full scale institutionalization became the norm. But with the creation of asylums as communities for the mentally ill, it did not take long for conditions to deteriorate markedly (Rosen, 1968).

The asylum as community system was perfected, so to speak, in the 19th century. The basic postulate of the asylum program was the prompt removal of the insane from the community to an institution which was itself separated from the community. This trend was accompanied by a shift towards custodial care of patients instead of the previous emphasis on moral treatment (Caplan, 1969). Under a new centralized system of welfare institutions, America witnessed the birth of thirty new institutions between 1870 and 1880 alone, and for the first time, a unique group of experts, the psychiatric profession, emerged (Grob, 1973).

Perhaps the single most important influence to spawn
interest in the geography of mental health was the community mental health movement. The roots of this movement can be traced to the early 20th century, when the poor conditions, in terms of overcrowding, decreasing emphasis on treatment and increasingly inhumane conditions in mental hospitals led many to consider new philosophies for the treatment of psychiatric disorders (Bassuk and Gerson, 1978; Segal and Aviram, 1978). As a result, mental health professionals began to consider the possibility of once again involving the community as an active agent for treating mental illness. The community mental health movement emphasized small scale mental health facilities in the community and a largely preventative orientation, providing services such as crisis management training and psychiatric counselling (Caplan, 1982). But a dominant characteristic of the resultant community mental health movement has, and continues to be, the implementation of massive deinstitutionalization programs, and relocating the discharged patients to small scale treatment facilities (Bassuk and Gerson, 1978; Segal and Aviram, 1978; Dear, 1978). The full implementation of the community mental health movement was realized quickly. By the 1970's patient numbers had decreased rapidly in North America, and to a lesser extent in Europe (Dear and Taylor, 1982). Not surprisingly, such a shift of locale for mental patients raised new questions about the rather nebulous status of the notion of community for them (Wolpert and Wolpert, 1974).

Hence the geographer has a valid interest in the links between mental health and the concept of community. While
geography and physical illnesses have proven to be a rather compatible combination for a long time now, the interest in mental health has been a relative newcomer to the discipline, perhaps because of the lack of obvious spatial connotations in this area. As C.J. Smith has commented, "If mental illness were contagious, geographers probably would have begun to study it long ago." (Smith, 1977, p.1). But in the past decade especially, a multifaceted "geography of mental health" has developed, shedding new perspectives on this broad area of inquiry.

DISTANCE AND LOCATIONAL CONSIDERATIONS

It is not surprising that locational considerations have figured prominently in the geographic mental health literature, especially in the early stages. Such studies have tended to explore optimal public facility location rather than being specific to mental health. More often than not, they were based on gravity model or other economic approaches, stressing accessibility over other concerns (e.g. White, 1979). Related studies have explored equity as well as efficiency and their relative weightings as criteria for location, thereby refining previous efficiency-only related work (e.g. McAllister, 1976). Wolch (1978), on the other hand, questions the benefits of utilizing these traditional accessibility-based approaches, suggesting that a concentrated locational pattern, generating internal scale economies, may prove to be more beneficial to clusters of service dependent people such as former mental
patients. In Wolch’s view, since "journey to service" variables replace "journey to work" variables of traditional models, a more concentrated pattern would prove to be beneficial to clients frequenting more than one service facility, or allow individuals a choice of the facility they attend.

Quite predictably, postulated distance effects also have been the focus of much work. Studies relating user distances to mental health facilities and effectiveness have demonstrated that distance to facility or hospital plays an important role in treatment (Weiss, et al., 1967) or utilization rates (Weiss, et al., 1966; Sohler and Shepard, 1971; Shannon and Dever, 1974), but have not produced much consistency of results. A divergent viewpoint is outlined by Smith (1976a) who, in agreement with other authors, questions the a priori use of the distance variable as a basis for analysing the location of mental health facilities. While distance may yield some explanatory power, it is likely that as a variable it may be merely acting as a surrogate measure for other, more important variables. These other variables might include factors more directly related to the client or facility itself, such as plans or abilities of the client, one's desire to leave, or the expectations expressed by medical staff. In fact, Smith’s analyses incorporating such variables lend support to his assertion that the significance of distance must be deemphasized in public policy issues.
The Community Mental Health Movement was perhaps the single most important influence to spawn interest in the geography of mental health. The dominant characteristic of this movement has, and continues to be the implementation of massive deinstitutionalization programs. The resultant shift in populations from large-scale institutions to the community was facilitated by several, seemingly independent factors. The development and introduction of powerful new psychotropic drugs and new techniques in psychiatry, along with the more gradual changes in attitudes toward mental illness in general were instrumental in providing the impetus for this movement (Segal and Aviram, 1975; Dear and Taylor, 1979; Bassuck and Gerson, 1978). Of no lesser importance, increasingly negative sentiments toward lengthy hospitalization and concerns for fiscal conservatism, which could be realized by the shifting of monetary costs of providing mental health care, further influenced the tendency toward deinstitutionalization (Dear, 1978).

The full implementation of the Community Mental Health Movement was realized quickly. This is evidenced, for example, by the situation in British Columbia. In 1966, the locus of mental health care was clearly centralized in the provincial mental institution Riverview, with a caseload of 7554 patients. Concurrently, the client load of all community mental health facilities accounted for only 5877 others (Colls, 1976). By 1979 the situation had more than reversed. The provincial
health ministry reports "typical annual caseloads" at Riverview to have reached a low of only 1,100 patients, representing a drop of over 6000 in this one institution, while community facilities and boarding home programs have a total annual case-load of 12,600 clients (Province of British Columbia, 1980, p. 156). It is quite understandable that such a massive and relatively rapid shift of loci should have left visible and problematic marks on many communities. While deinstitutionalization has been heralded by many, a closer inspection of the problems that have been created has fostered a much less positive outlook among others.

For some, deinstitutionalization has seemed to have accomplished little more than transferring the asylum to the community. In other words, the locus, not the focus has changed. Phrases such as "asylum without walls", or references to the "ghettoization" of the mentally ill, point to one of the unanticipated, or at least unintended consequences of large-scale deinstitutionalization. Wolpert and Wolpert (1976) comment, that placed in surroundings without support or a beneficial physical environment, ex-patients face a situation of neglect similar to, or even surpassing the effects of over-hospitalization. Because of difficulties in implementing policies to provide supportive housing in stable residential neighbourhoods, ex-patients and other service dependents, dealing with welfare budgets, saturate inner city areas. In effect, they are once again in a non-supportive environment with inadequate housing, diets and incomes. Effectively, the
endeavors of hospital officials to avoid overhospitalization have resulted in underhospitalization because of a lack of half-way environments, and, consequently, a new epidemic of persons requiring additional treatment. According to Wolpert and Wolpert (1976, p.33), "the (deinstitutionalization) policy has succeeded perhaps too well". While observing that deinstitutionalization processes have had positive repercussions on fiscal, civil rights, therapeutic and treatment considerations, they note that many of the projected goals for an "inclusive society" have been undermined in the process. Wolpert and Wolpert (1974) demonstrate that it is possible to predict the number of facilities necessary for discharged mental patients while still avoiding the oversaturating of susceptible neighbourhoods. They emphasize that,

If many continue to be hospitalized simply because they are unwanted by communities, if those who are released face a severe decline in the quality of their life and if community preventative services fail to reduce the need for confinement, the public mental health sector will have once again failed to fulfill its mandate". (Wolpert and Wolpert, 1974, p.50)

Patients who have been released from institutions to settings beyond their tolerable autonomy levels\(^1\) are those who frequently become entangled with judicial authorities, or are victims of the revolving door syndrome of being repeatedly

\(^1\) This phenomenon of psychiatric patients being released into communities lacking adequate support services suitable to the discharged patients' autonomy levels is frequently referred to in the literature as "dumping".
admitted to and discharged from mental institutions (Dear and Wolch, 1979). Reich (1973) asserts that these individuals form the weakest groups of the urban population, and therefore are quite susceptible to falling prey to stronger, unscrupulous sectors. Adamantly, he states that this represents "a return to the Middle Ages, when the mentally ill roamed the streets, and little boys threw rocks at them" (Reich, 1973, p. 912). In any case, while such a pessimistic perspective may not be warranted, geographers have been very aware of these more problematic aspects of deinstitutionalization. They have been explored by geographers in terms of the phenomenon itself, and as an integral part of the urban system from a variety of viewpoints, as shall be outlined below.

The formation of spatial concentrations of former mental patients has been documented, for example, in Hamilton, Ontario (Dear, 1977), San Jose, California, Washington, Detroit and New York (Wolpert and Wolpert, 1974) and other cities (Wolpert and Wolpert, 1976). In Canada, Beamish (1981) analyses these changes in terms of increasing proportions of service dependent individuals in inner city populations. The proliferation of former patients and other service dependents can be attributed to a formal process whereby patients are assigned to agencies in particular areas, or to an informal filtering process of patients gravitating to inner city areas. Such areas provide not only cheap rental accomodation, but are the locus of large houses easily convertible to half way facilities and group homes (Dear, 1977, 1981).
The counterpart to the ghettoization of patients, the clustering of support facilities themselves has also been noted. Philadelphia provides one such example. However, in this case the utility of the observed spatial clustering is under question. Even though the clustering was identified in areas deviating from the 'middle class norm' (high percentage of renters, people residing in group quarters, an abundance of older people), it was not clearly established whether these facilities were located in areas of high community instability (Coughlin, et al., 1976).

In Toronto, Joseph and Hall (1985) demonstrate the disproportionate distribution between population size and the number of facilities in Toronto, both at the scale of the borough (Metropolitan Toronto) and minor planning districts (City of Toronto). In this study, the use of location coefficients and coefficients of localization, based largely on the work of Joseph and Phillips (1984) are applied to yield quantitative information in a simplified form which may hopefully be of use to planners, theorists and local governments. Notably, Joseph and Hall recognized the importance of including facilities not officially recognized by policy makers (for example, facilities in addition to those included in provincial ministry lists). Even though an adherence to official lists would have yielded a differing distribution, they concluded that the concentrations noted would not be markedly different.

The mushrooming of concentrations of services and service dependents, or the trend toward the "public city", has
been argued to represent an inherent structural feature of urbanization, necessary to instill social reproduction. Dear (1980) theorizes that the formation of the public city is the result of two concurrent processes: inner-city abandonment and deinstitutionalization. Given these conditions, the service dependent populations, typified by limited incomes and mobility, form an available market to fill the vacuum created in the inner city. The resultant spatial delineation of populations (which may be reinforced by the state through planning mechanisms) is seen to be instrumental in setting in motion a self-reinforcing process reproducing the social and spatial inequalities already existing. Thus from this perspective, the public city is seen as a functional, inequality reproducing unit rather than an ad hoc clustering of people and services. However, it is important to realize, that by the author's own admission, the existence of the public city may be disputed. Smith (1975) convincingly argues that examples of spatial concentrations of clients and facilities cited in the literature may not be representative of urban centres in general. Rather, centres such as San Jose (documented by Wolpert and Wolpert, 1974) may be the exception rather than the rule, because of the massive numbers of ex-patients being discharged at one time, coupled with the existence of large scale areas fitting the description of 'ghetto'. Therefore, the existence of the public city is recognized. However, one must question how widespread this phenomenon has actually become, and pay attention to the particular characteristics and
circumstances which give rise to the public city.

COMMUNITY OPPOSITION TO COMMUNITY-BASED MENTAL HEALTH FACILITIES

In any event, it is apparent that some neighbourhoods are more affected by the influx of community mental health facilities, boarding homes and other group homes than others. In many cases, neighbours have expressed vocal opposition to their proximate location or concern over the number of facilities in an area. Studies exploring community opposition to community mental health facilities, then, account for a sizeable proportion of work completed in the geography of mental health. The sum of the findings in this area can most adequately be expressed through the titles of two recent publications on this subject: "Not On Our Street" (Dear and Taylor, 1982), or "Any Place But Here" (Smith and Hanham, 1981).

It is necessary to qualify, however, that more often than not, these kinds of sentiments are those that are most heard, not necessarily those most 'felt', that is, they in all probability may not accurately represent general community consensus. In Toronto, for example, Dear and Taylor (1979, 1982) note that while levels of debate over the proposed locating of community mental health facilities in neighbourhoods are substantial, a puzzlingly low level of negative response toward facilities, and very low levels of awareness of the actual facilities are actually observed. Dear and Taylor concluded that opinions may have shifted in light of the emergent controversies over these facilities, but suggest that it is most
likely that the opposition was limited to those not representing community feelings in general. Researchers have noted that attitudes toward mental illness and community mental health facilities are generally favourable. Still, it is the relatively small, volatile, vocal, and above all, well organized opposition which frequently succeeds in barring the location of facilities in neighbourhoods (Dear and Taylor, 1979, 1982; Smith, 1980; Taylor, Dear and Hall, 1979).

Reasons for the perceived noxiousness of community based mental health facilities have been explored. For example, an experimental study by Smith and Hanham (1981) assesses the impact of 'noxious' facilities by type and scale. Dear, Fincher and Currie (1977) distinguish between tangible and intangible externality effects of such facilities as a basis for residents' concern. Judging from reasons typically given as bases for apprehension about neighbourhood facilities as, for example, recorded in the Toronto Globe and Mail and The Toronto Star over a seventeen month period between January 1977 and May 1978, both these effects surface frequently. Opposition based on such factors as personal or family safety, or dislike of facility users provide examples of the intangible externality effects, while the tangible effects mentioned include increases in traffic problems and noise (Dear and Taylor, 1979, 1982).

Little research has been completed to ascertain the justifiability of these fears. Studies examining the claims of effects on property values, a frequently cited externality
effect stemming from the introduction of community mental health facilities, have been found to be largely unwarranted (Dear, 1977; Dear and Taylor, 1982; Wolpert, 1978; Boeckh, et al., 1980). Research in this area suggests that many of the concerns voiced by residents may be based on stereotypical rather than actual threats.

A third aspect of community opposition to community-based mental health facilities with which geographers have been concerned is the problem of identifying suitable neighbourhoods in which to locate them. Since the community acts as 'host' to the facility, the characteristics of the neighbourhood play a vital role in the functioning and effectiveness of the facilities themselves. There is, however, no one set definition of these characteristics. Smith (1976b, 1977, 1978) suggests the importance of physical and social attributes which directly contribute to low-stress enjoyable environments as a key to therapeutic success. Trute and Segal (1976) focus instead on the level of social cohesion in neighbourhoods, arguing that lower levels of social cohesion provide less 'closed' and more integrated environments, a concept also pursued, albeit less explicitly, by Smith (1975) and Wolpert (1976). Dear (1977) points to the significance of facility design itself, while Segal and Aviram (1978) suggest the somewhat broader interplay between community characteristics, facility and resident characteristics, and facility form.

A vast, yet seemingly inconsistent, body of sociological literature has explored the relationships between socio-
economic and cultural characteristics of individuals and attitudes toward mental illness. Geographers have drawn on this knowledge in order to identify suitable areas for community-based facility location on the premise that such characteristics contribute substantially in predisposing attitudes toward public facilities. This research has been targeted both at neighbourhoods and at individuals (Dear and Taylor, 1979, 1982; Pulcins, 1980).

SPATIAL AND SOCIAL SEGREGATION OF THE MENTALLY ILL

It should be apparent that the literature cited to this point has all been based, either directly or indirectly, on the exclusionary forces operating at metropolitan and neighbourhood scales to isolate the mentally ill, spatially or socially, especially former long term mental patients. These processes have been expressed formally by several authors. On a community level Segal and Aviram (1978) describe how opposition to community based mental health facilities may be manifested through the exclusion of the mentally ill by either formal or informal mechanisms. The social and spatial segregation of the mentally ill has also been integrated into a Marxian theory of the state (Dear, 1981). This analysis focuses on the role of space as one key element in the social reproduction of class relations. Both Dear and Peet argue that inequality is per-

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2 An excellent and thorough review of this literature can be found in Rabkin (1972). Although dated, this review has lost little utility since the bulk of studies dealing with this subject were completed in the 1950's and 1960's.
petuated by individuals being locked into a "prison of space and resources" (Peet, 1975, p.568) which in the case of the mentally ill, may represent the asylum, the ghetto, or the 'closed' community. Furthermore, Dear implicates the active role of the state in the social and spatial reproduction of the mentally ill, occurring most often through urban planning strategies.

Several geographers have discussed the theme of biased planning strategies, although not necessarily within a Marxian framework. It has been pointed out, for example, that "least risk" zoning regulations are instrumental in restricting mental health facilities from some neighbourhoods, while consequently saturating those where least opposition is anticipated (Wolpert, et al., 1975; Segal and Aviram, 1978; Dear and Taylor, 1979, 1982). Joseph and Hall (1985) also comment that differential policies, or rather a variation in the translation of provincial policies as well as discrepant municipal bylaws are largely contributory to the varying levels of saturation of group homes between Toronto municipalities, and at a district scale, also within these municipalities. Furthermore, significant discrepancies in placement policies (of clients to facilities) within specific areas have been noted to encourage facility saturation in some neighbourhoods.

Similarly, Mumphrey, et al. (1971) outline a "Political Placation Model" for locating controversial facilities. Essentially, this model is based on the assertion that such decisions are directly reflective of power in the respective
communities involved, thereby differentiating between those which may be ignored and those which must be placated. In summary, it is recognized that some planning policies may exacerbate the isolating forces directed at those returning to the community.

NEIGHBOURHOODS AS SUPPORTIVE NETWORKS

Not all work in this field, however, is focussed on the exclusionary aspects of community. In fact, much attention has been directed at the supportive function of the urban community, which from this perspective is viewed as being vital not only to the reintegration of former patients but to the maintenance of mental health as well.

The role of social supports in all areas of health care is considered to be an essential contributor to general well-being, as an aid to health maintenance and recovery, and as an important source of information pertaining to the availability of services and other health related resources (Dimsdale et al., 1979). The existing urban structure can and does provide support (Smith, 1981) in neighbourhoods through formal and informal mechanisms (Smith, 1980b). The networks through which ties are established have also become a target for much research. Studies have examined the extent to which support networks are in operation in urban areas (Wellman, 1979), and the characteristics of the resulting ties and structural characteristics of the networks themselves (Wellman, et al., 1975). The importance of social networks is not be be underestimated;
it has been suggested that an intensive, thorough researching of social networks could lead to a "truly preventative study of mental health" (Smith, 1980c, p.519).

SELF-HELP: FORMALIZED SUPPORT NETWORKS

Looking beyond the realm of the marketplace, to our own communities for support and services is becoming re-established as a notion central to service provision. Time has shown that professional caretakers alone cannot combat mental distress. Perhaps it is this awareness, coupled with the recent discharge of large numbers of patients into unprepared communities that has fostered the mushrooming of self-help and mutual aid groups for former mental patients. Such groups serve several purposes, but have been formed primarily to facilitate the formation of networks to help former patients aid one another in landing feet first into the community. Or, they may operate on a more preventative basis, assisting individuals to cope with daily stress and distress before problems increase in proportion to the extent that they may be labelled as mental illnesses.

In spite of their rising popularity in the last decade, self-help in mental health is not yet a well understood term, and is often confused with other types of facilities. While self-help facilities may appear, in form, to be similar to community mental health facilities, the type and concept of care offered by each differs radically, since the latter involves largely professional care which is administered to the
patient. Self-help, on the other hand, may be seen as an alternative to the conventional, professionally dominated mode of mental health care. Owen (1978) offers an excellent definition of self-help groups, characterizing them as:

voluntary small group structures for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common handicap or life-disrupting problem, and bringing about desired social and/or personal change. The initiators and members of such groups perceive that their needs are not, or cannot be, met by or through existing institutions (Owen, 1978, p.5)

Gartner and Riessman (1977) describe four major themes characterizing the self-help movement: (i) a common purpose (for example, aiding ex-mental patients to cope in the community); (ii) a non-hierarchical structure within the organization itself; (iii) a focus on the equalization of power instead of further stratification (e.g. between physicians and patients); and finally, (iv) social change. Thus self-help groups, by providing knowledge to the client, challenge the existing power relationships between physicians and clients, as well as providing services not typically provided by mainstream agencies. Furthermore, underlying the group-specific goals in the self-help movement, are broader, radical goals which challenge the status quo. In this manner, the goals of the self-help movement transcend the boundaries of mental health to the broader issue of equalizing power in the medical establishment and other elements of society.
Illich (1981) contrasts self-help (within the scope of what he has coined the "shadow economy") to "autonomous" or "vernacular" life. Whereas in industrial societies there exists a clear division between production (as, for example, that person or entity who is licensed to provide medical care) and consumption (which may be represented by those who need help as defined by the professional), in the shadow economy they are brought together, and both at once are projected onto the individual. Therefore one is able to produce himself that which will be consumed. This, in turn, produces a utility which adds, in an albeit complex manner, to the GNP. Thus the emphasis, where self-help is concerned, is now on "utilization values", since the tendency has been to lose them throughout the course of modern economic expansion. According to Illich, the manner in which economic development has occurred has assured that individuals must purchase aid, since it has, in effect, become commodified. Within a self-help framework, however,

there is an open acknowledgement that care-giving is a two-way influence and benefit process, not just the transferral of some esoteric knowledge from a professional to a client. (Owen, 1978, p.6)

Furthermore, since many of the physical, economic and cultural conditions for effectively existing without professional or other purchased help have been lost, people must obtain aid in commodity form. Of course, self-help has become a reaction to this phenomenon, as an alternative to already established forms
of (medical) aid. Illich optimistically predicts that the self-help mode of service and health care provision can come into full force during the 1980's.

Self-help, then, is firmly rooted in the notion of the primacy of experience over professional training and credentials. The belief that non-professional care is not only adequate, but superior in that it may allow for a greater diversity of ideas and approaches lies at the heart of this movement. But equally important for the realization of a true self-help model is a sense of group responsibility, since it is this collective consciousness which differentiates between mutual aid and simply helping oneself. Without it, self-help becomes "another therapy or another package deal in the service supermarket" (Owen, 1978, p.7).

Kleiber and Light (1978) list three major implications of a self-help model. Firstly, consumers and providers of mental health care are not stratified by their training or status within the self-help framework, so that the concept of sharing technical information and therefore power (usually the restricted domain of the professional) are stressed. Similarly, personal responsibility is emphasized in lieu of professional control. Secondly, the traditional hierarchical structure is abandoned in favour of egalitarianism. Lastly, more attention is devoted to individuals which in turn facilitates a greater degree of information which can be dispensed. Also, lay workers do not carry the costly price tag of the professional. Thus self-help represents an intermediate level of care-giving,
a response to the power depleting concept of health care offered by the conventional professional mode (Owen, 1979). Equally, self-help presents a useful model for the more established forms of health care delivery, in its role as consumer advocate, pointing out the deficiencies present in the current delivery system (Durman, 1976).

The Mental Patients' Association in Vancouver represents one example of a self-help group. This particular group operates to provide practical and emotional support for ex-mental patients, through a drop-in centre, alternative housing, advocacy and so on, but their position is characteristic of self-help groups in general:

> Our structure and approach to mental health differs radically from that of hospitals and professionals in that we feel people who have gone through rough times themselves are qualified to help others going through similar experiences. The emphasis is on concern and empathy. (Mental Patients' Association, in Carter, 1974, p. 269.)

More specifically, the Vancouver Mental Patients' Association (MPA), like similar self-help groups, aims to provide a wide array of services. The MPA evolves around the Drop-in Centre, the locus for MPA offices, general meetings, activities and crafts, informal gatherings, and also weekly and holiday meals. In addition to scheduled and special activities and a place merely 'drop by', the centre offers financial counselling, housing referral for former mental patients and legal advocacy services for current patients.

The MPA also operates five group residences and one
apartment style residence exclusively for ex-mental patients. All prospective residents are required to be MPA members and be approved by a majority of residents. The residences and apartment function on the basis of group decision making and mutual support, although in the latter, higher levels of independence for residents is encouraged.

Individuals may become members of the MPA by going to the drop-in two times, and then attending a general meeting. The general meeting presides over all policy, program and fiscal decisions, reflecting the democratic, non-hierarchical organizational structure of the association. Currently the MPA publishes a monthly newsletter, which is distributed to institutions and individuals, and has set up ad hoc committees to research the use of drug and electroconvulsive therapies in psychiatric institutions as part of their ongoing involvement in research and advocacy. However, mutual support and the understanding of mental illness from a lay perspective remain the main principles of the MPA.

Indeed, throughout North America, the mental patients' self-help movement has expressed its strive toward the realization of patient controlled mutual support alternatives to the established psychiatric system, and also a vehement opposition of current psychiatric methods and principles. This trend may be evidenced in two position papers produced by the mental health self-help community. Firstly, the Mental Patients' Declaration of Principles (Appendix I) represents the beliefs of an active and radical sector of the mental patients' move-
ment. This document illustrates their deeply rooted opposition toward incarceration (involuntary assignment to psychiatric institutions), and questioning of treatment procedures in these institutions on the basis of their scientific validity as well as in terms of possible human rights infringements incurred by involuntary treatments. The psychiatric system is strongly criticized, and much emphasis is placed on its power depleting and discriminatory effects on patients, which are further exacerbated by existing racial, and gender or age-based inequalities. The sector of the self-help movement represented in this document is highly skeptical of the utilization of the medical model as a basis for understanding and treating mental illness. They demand a reevaluation of the psychiatric system, and an expanded implementation of voluntary mutual support alternatives, expressly self-help.

Similarly, a very vocal mental health self-help organization has issued a Bill of Rights for Psychiatric Inmates in Canada (Appendix II). Many of the same concerns surface here, especially the extremely antagonistic stance toward the psychiatric profession and psychiatric system. Major issues addressed include: incarceration, personal property, legal rights, and individual control as opposed to control over individuals. Thus the string of self-help groups for ex-mental patients share several common threads, as outlined above: an interest in the mutual aid function, a non-hierarchical structure of care-giving, and assuming an advocacy role within the current system.
Self-help is not a new phenomenon, by any means, but has recently witnessed an unprecedented boom in the appearance of new self-help groups answering to a wide variety of needs. In fact, the 1954 International Conference of Social work prompted self-help as a tool for acquiring higher degrees of social welfare. But even earlier, groups such as the "Friendly Societies" in Britain, which functioned as occupational self-help groups are viewed as the forerunners of twentieth century self-help groups. These groups date back to the late sixteenth century, numbering 191 by 1800. In the United States, self-help among colonial farmers was initially of the informal, spontaneous variety, but did evolve into mutual assistance groups resembling cooperatives among dairymen and farmers. In fact, self-help, in some form or other can be evidenced throughout the past three centuries. The more 'modern' forms of self-help with which we are concerned here started to appear after the second world war (Katz and Bender, 1976a).

Recent appraisals estimate that several hundred thousand self-help groups may be in operation, including both large national and international groups (e.g. Alcoholics Anonymous) and the numerous local, smaller scale groups that are of particular interest here (Katz and Bender, 1976z). Naturally, a large body of literature dealing with this subject has accumulated. Much of the literature has described self-help in theoretical terms, or has assessed the relative costs and benefits associated with the self-help mode (Gartner and Riessman, 1974, 1977; Katz and Bender, 1976b). From a
different perspective Chamberlin (1978) provides a personal, first-hand account of the benefits of self-help to its clients, and, conversely, the relative ineffectiveness of conventional psychiatric assistance.

However, little information is available to shed light on the problems associated with the actual implementation of active self-help groups in the community. This, in fact, is a serious consideration, since it is apparent that the introduction of self-help groups as an alternate mode of mental health care may present a serious threat to individuals and organizations who form the currently prevailing system of mental health care delivery. Not only does the self-help movement closely coincide with a critique of the helping professions (Borremans and Illich, 1978), but it also emphasizes a restructuring of the medical system and in many cases the broader power relations in society as a whole (Kleiber and Light, 1977).

The intention of this study is to lessen this theoretical and empirical gap, to a small extent, by investigating the transition self-help groups make in becoming an operational entity from their theoretical ideal. Particular importance is placed on the barriers self-help groups may face in passing through such a transition. In the next chapter, a model of operationalizing the self-help concept will be developed, focusing directly on these hypothesized barriers. Chapter Three addresses the research design employed to apply this model to a study of self-help groups and outlines the
issues of sample selection and research methodology. The last two chapters are devoted to an analysis of self-help groups, assessed according to empirical data collected in Vancouver, B.C. The effects of the hypothesized barriers on the operationalizing of self-help groups are discussed in Chapter Four. In Chapter Five, the Vancouver groups' operational 'outcome', the final component of the model, is evaluated. Finally, the theoretical implications of these findings are discussed, thereby further suggesting some of the broader issues associated with implementing a self-help mode within the present system of mental health care delivery.
CHAPTER TWO
TOWARD AN OPERATIONAL MODEL OF IMPLEMENTING A
SELF-HELP MODE OF MENTAL HEALTH CARE

Operationalizing a theoretical model of any sort may typically be not unlike travelling an infrequently used road, encountering potholes, overgrowth and washed out bridges along the way. Here, the transition to operationalizing a self-help mode of health care is viewed in much the same manner. Considering some of the elements which are not favourably disposed toward a full-scale introduction of self-help in mental health, such as some sectors in the community for whom self-help represents a marked departure from the established institutions of which they form an integral part, one can foresee a wide array of obstacles self-help groups may confront in attempting to establish themselves.

A conceptual model of the operationalization of a self-help mode of mental health care, from conception to implementation, is presented in Figure 1. In this model, the self-help concept is regarded as the central element, but important components of this model include public policy, the professional, and the community. These latter three components are seen as playing a vital role in determining the form self-help groups will take, and are treated as a system of highly interconnected primary or direct links (as indicated by heavy lines) and secondary or indirect links (as indicated by fine lines). These links between policy, the professional and the
FIGURE 1

CONCEPTUAL MODEL OF THE OPERATIONALIZATION OF SELF-HELP GROUPS
community, which mediate between the conceptual and actual form of self-help groups, explain how the actual working self-help model may deviate from the intended model. Of course, it is important to point out that the distinctions between the various components in this model constitute artificial divisions since they are tightly interconnected, but they at least provide manageable means with which to examine this process. In the following section, each of these components, state policy, the professional, and the community, and their interconnecting links, shall be dealt with separately, and finally, possible outcomes will be discussed.

PUBLIC POLICY AND THE STATE

Most, if not all, self-help groups in mental health direct their attention not only to medical concerns, but social, economic and especially political concerns as well (Borremans and Illich, 1978). Many of the projects undertaken by such groups are innovative to the point that they may be considered 'politically nonfeasible' by other organizations or individuals involved in mental health care, or social service provision in general (Carter, 1974). Moreover, self-help approaches to mental health emphasize the need for redistributing power and resources. Thus as a movement attempting to achieve this, they are, by definition, essentially political (Owen, 1978). Other authors are much more emphatic in this respect, stating that:

Self-help is, of course, socialist.
There is no money to be made from self-help because people can
decide for themselves whether or not they need drugs, services and expensive professional care. (M. Smith, 1978, p.26)

Thus the self-help alternative may represent a confrontation with the basic interests of the state, since their actions threaten the status quo. Although as Schur (1980) points out, because the actions of self-help groups are not likely to threaten significantly the social and political order, they may, in fact, pose an indirect rather than direct threat to the state. In any case, the degree to which such movements may be seen as threatening is difficult to determine.

Nevertheless, some state functions, such as funding, have been identified as cooptive forces with respect to the activities of the voluntary sector. On one extreme, activity which does not conform to the political arrangement of the state may not be funded at all (Loney, 1977). For example, in British Columbia, the Ministry of Human Resources (responsible for funding those services which would not, in the case of mental health, fall under the jurisdiction of the Ministry of Health) specifically states that proposed services "must be supportive of Ministry services" to receive funding (Community Contract Services Program, 1979). Most financing mechanisms, such as provincially administered health insurance, do not cover lay or self-help services (Chu and Trotter, 1974). Thus, since local groups must usually deal with such provincially and federally instigated policies, they lack the power to overcome constraints against effecting "even small scale change" (Wharf, 1979). Low income groups, which certainly include, for
example, ex-mental patients, are most affected by the particular policy orientations of governments, since they have no other readily accessible funding sources available to them (Loney, 1977), as is the case with some community organizations. Locally, there is evidence that such groups are facing this dilemma, as witnessed by newspaper articles in the past entitled, for example, "People drop in - but funds drop out" (Vancouver Sun, August 17, 1979).

Beyond the issue of merely obtaining funds, however, is the predicament such groups may face upon receipt of government funding. In this sense, funding has been referred to as the necessary evil; it is essential for any organization in order to survive, yet at the same time it may imply cooptation because of the inbuilt requirement to be accountable to the funding source (Kleiber and Light, 1978). As noted by Loney (1977) the direction and objectives of a program may change in order to comply with the conditions stipulated by the funding source, even if the groups in question have to compromise their initial ideals.

This funding will necessitate the organization shifting activities toward offering concrete programs which are in reality often little more than appendages to the existing social service delivery system. (Loney, 1977, p. 468)

Groups, pressured to ensure ongoing sources of funding, will attempt to fulfill the donor's criteria, at least on paper, although those may differ from their own objectives.

Similarly, Fincher and Ruddick (1983) note the
incidence of state policies in Quebec which effectively transformed health care services into a commodity form (contrary to the objectives of Illich's 'shadow economy') under the guise of centralization of health care. With the change in organization came a health care facility which varied significantly in the type and concept of care provided by the original centres.

In reference to the urban community movement, Lemon (1978) notes the emergence of an individualistic culture, and the consequent resistance to grassroots community participation. While observing support for, and recognition of, neighbourhood based services, Lemon stresses the rather stronger actions of the local state to curb any such activity, and suggests four arguments used as the basis for the reluctance to support such groups. Firstly, electoral democracy is viewed as the cornerstone of fiscal control in our communities. Lemon shows that self-help groups are seen as coming dangerously close to controlling the economic mechanisms at local levels, where this process should be left in the hands of the elected officials. Interestingly, Lemon notes the perseverance with which the system of electoral democracy is perpetuated in spite of the low levels of voter turnouts. Secondly, it follows that the legitimization of grassroots organizations is potentially threatening to the currently standing legitimacy of elected politicians and the governing system they uphold. Therefore, the attempts not to give a sense of legitimacy to self-help groups has probably affected their resulting relatively low levels of activity. The control of economic resources represents a third
argument and hindrance. Local governments are often fearful of public reaction to the utilization of public monies for the public good. Therefore, allocation of funds has often been inconsistent at least, although grassroots movements have rather consistently been the first to be affected by cuts.

Welfare mothers, the unemployed, and community workers are said to be "free loading"; business, especially large corporations that receive massive grants from government both directly and indirectly through tax concessions, are not. The old adage more than ever holds up in these days of cutbacks: free enterprise is for the poor; socialism, for the rich. (Lemon, 1978, p. 328)

Fourthly, Lemon notes that "the ideology of free choice advocating voluntarism for public involvement" also hinders self-help organizations. This paternal philosophy, which does not involve group commitment to a common cause, does not lend itself to the establishment of a 'public' as opposed to 'private' household. Yet in spite of these four arguments, which have been used to discourage the formation of self-help groups and other such organizations in the development of the public household, Lemon notes that it is becoming a viable reality, but a reality requiring great energy, momentum and fund raising ability.

Thus, in summary, because self-help offers an alternative not only in the realm of mental health care, but may have more widespread political ramifications with respect to the distribution of power in society as a whole, it may be threatening to the various levels of government controlling
health care provision. Findings in the literature suggest that the state may take actions to curb any wide-spread growth of the self-help movement, especially under the auspices of funding policies. The possible effects of such an action are two-fold. First, by barring monetary support, the formation of self-help groups may be halted. However, more often such groups may receive funds but suffer the effects of cooptation because of the involvement and control the state is able to exercise through demanding accountability for received funds. This latter option may be especially relevant during the present period of fiscal cutbacks, since the self-help alternative may be viewed by the state as a less costly manner in which to deliver mental health care. In any event, it is in this manner that the actual programs of self-help groups in mental health may differ significantly from their originally intended formulations.

THE PROFESSIONAL AND THE PROFESSIONAL ETHIC

The fundamental principle of self-help, that is, the primacy of the benefits of actual experiences (in this case, mental illness) over credentials and technical knowledge (Owen, 1978), undermine the importance of professional care and may, therefore, be seen as threatening to the professional healer. As mentioned previously, the ideologies and activities of many mental health self-help groups imply not only a critique of the asymmetric and potentially exploitative practice and the broad scope of problems which professionals tend to 'psychia-
trize', but a profound questioning of the basis of mental illness in general.

As Goffman, Szasz and Laing have suggested, mental illness as opposed to more concrete, physical ailments, is extremely dependent on psychiatric judgement and therefore on its entire underlying value system (Illich, 1976). In other words, the definition of mental illness is tenuous. For example, one particular study quoted in *More For The Mind* (1963) determined that only nineteen percent of the total population was free of symptoms indicating mental illness. At the other extreme, it has been suggested that,

> The evidence available seems to support the view that what people now call mental illnesses are, for the most part, 'communications expressing unacceptable ideas, often expressed in an unusual idiom'. (Allen, et al., 1978, p. 15)

Thus in most cases, the definition of mental illness may well entail a larger social rather than medical component (Watkins, 1975). This concept is systematized in labelling theory, and despite the limitations of this perspective, the fundamental ideas are difficult to refute (for two very different critiques, see Gove, 1975; Schur, 1980). Generally, by labelling an individual with a particular mental illness, on the basis of available psychiatric tools, a permanent stigma is produced whether the tag be criminal (Lowman, 1983) or schizophrenic (Illich, 1976; Rosenhan, 1973; McKnight, 1977).

However, mental health professionals continue to increase their power and scope of intervention, which in turn
perpetuates an asymmetric relationship with their clients (Dear, 1981). This extension of professional jurisdiction in the area of mental health may be evidenced in a report of the Canadian Mental Health Association More for the Mind (1963) in which recommendations included expansion of psychiatric influence in areas including geriatrics, corrections and rehabilitation services, schools and industry. While such services do represent an expansion of help offered to individuals, they may also contribute to a decreased ability in people to respond to and cope with problems, changes and anxieties, or at least an increase in dependency. Consequently, individuals must increasingly resort to treatment and professional help instead of taking matters into their own hands (Illich, 1976, 1981). The extent to which this dependency has been generated is difficult if not impossible to determine from existing data. Yet certain inferences, albeit inadequate, may be made from analysing existing trends. It is obvious, for example, that in industrialized societies, capitalist or socialist, the number and variety of services is rising (McKnight, 1977). Also, although mental hospital populations are decreasing, this trend is more than compensated for by the rise in admissions and discharges. This has been demonstrated by Chu and Trotter (1974) in the United States, by Dear (1977) in Ontario and is apparent from patient movement statistics furnished by the Ministry of Health in British Columbia (Ministry of Health, 1950-1979). It is clear that the number of people under psychiatric care is rising steadily.
From a broad perspective, such tendencies within the service sector may be viewed in the context of the changing economic base. Bell's (1973) post-industrial thesis points to the shift in emphasis from goods to services, especially those such as health care. The interplay between this aspect of post-industrialism, and the 'new' primacy of scientific knowledge has lead to a new status class of service professionals, and, by implication, an increasing status and importance attributed to the service industries.

Lasch (1978) attributes the expansion of the service sector to the shifting role of the worker as producer to worker as consumer, and the diffusion of social control from the factory, to encompass all aspects of living, including mental health. Gartner and Riesman (1974) develop more fully the role of economic influences on health care, an analysis which centres on the success of neocapitalism in developing a new 'superproductivity'. In spite of the positive attributes of the rapid development of production, the capabilities of our productive system have resulted in a particular need to stimulate large scale consumer demand to absorb the excesses of production, and as one consequence of this, have contributed to a vast expansion of the human services. Gartner and Rieesman cite several positive aspects of such a shift, including the increased benefits accruing to large numbers of people, and expanding awareness of individuals' rights to services, the shift from industrial (polluting) activities to non-energy reducing (service) activities, and generally the
encouragement of a new forum for potential change. However, the problems stemming from these shifts are equally prominent, and may be due to profit seeking, social control, or medicalization.

The medicalization process, or the expansion of medical 'needs', is inextricably linked to the expansion of the service sector, in order to stimulate consumer demand. This may represent a manifestation of the quest for profit, especially by pharmaceutical and equipment manufacturing firms, medical organizations, and so on (Waitzkin and Waterman, 1974), or for the maintenance of the service economy in general. In either case, "the client is less a person in need than a person who is needed" (McKnight, 1977, p.74). In the creation of needs, client populations provide incomes and economic growth for the professional sector which they support, but under the label of care this political and economic reality is obscured. Thus, as a rationalization for a service economy, "Medicare, Educare, Judicare, Socialcare, and Psychocare are portrayed as systems to meet need rather than programmes to meet the needs of servicers and the economies they support" (McKnight, 1977, p. 74).

Inevitably, medicalization has resulted in increased professional jurisdiction over medical problems. Problems, whose solutions were at one time rooted in the family or community, are subsequently becoming the property of the respective professional. Society is said to be becoming exceedingly therapeutic in orientation, whether the 'therap-
eutive client' is an individual in severe psychological distress or participating in an encounter group. As a result, the therapeutic culture embodies ideological shifts, whereby traditional 'helpers' (for example, the family or clergy) are no longer viewed as satisfactory consultants. Instead, individuals yield to professionals (Foster and Williams, 1980). "The medical professional has first claim to jurisdiction of the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively" (Zola, 1977, p.52). Having achieved the "privilege to prescribe" the disabling characteristic of the health care professionals arises in the definitions of what may constitute a medical problem (Illich, 1976). Other authors have expressed similar concerns. Graziano (1972) stresses the campaigns to pursue potential clients which influence people to seek expert help if a psychological problem is suspected. The essential ingredient in this process is persuading people that their everyday anxieties constitute severe problems requiring immediate expert attention. This is not unlike the Candid Camera scenario related by Smith (1975) where a man is persuaded that a particular column is on the verge of collapse, and must be held up until the workmen arrive.

Hand in hand with the problem of the ever-expanding jurisdiction of mental health professionals is the matter of professional dominance over the client. Dear (1981), citing the work of Foucault, Zola and McKnight comments on the probability of the establishment, to varying degrees, of auth-
oritarian social relationships between physicians and patients within a delivery system where there exists a tendency to depend on the physician as a scientific/medical authority or sole access to a cure. Friedson (1970) has pointed out that the very structure of the medical profession is centred around the notion of professional dominance. Friedson presents a critical characterization of the interplay between society and medicine, partly as a response to the Parsonian doctor-centred schema, the cornerstone of medical sociology. The strength of Friedson's work lies in the manner in which the role of the physician is couched in the context of the institutions of medicine.

Friedson differentiates between a Parsonian collective orientation of physicians, and their actual performance, a discrepancy which may pose conflict between physicians, clients and the general public. Stratification, through the manipulation of information and specialized knowledge, and the importance attributed to professional autonomy are cited as barriers to a more effective system of medical care. Friedson's analysis indicates that inequalities of training are directly related to stratification and therefore also conflict. Change, however, may come about through structural reorganization to produce a system which "maintains the legitimate perogatives of the professional worker while insisting on his essential obligation to regulate himself in the service of the public" and enables "the patient to serve as an active participant in the process of shaping the services that are supposed to exist
for his benefit" (Friedson, 1970b, p. 236).

The matter of professional dominance is illustrated, for example, by the Canadian Mental Health Association, who recommend:

> that the psychiatrist be given the authority and final responsibility for the professional activities of the clinical team. (More for the Mind, 1963, p.35)

On an international scale, Ugalde (1980) has demonstrated the efforts of the medical community to gain control and supremacy in the health sector, thereby securing not only economic gain, but perhaps more importantly, considerable prestige in, and power over the health care system. In this manner, the ideals which are firmly rooted in traditional professional values are perpetuated. The professional community, however, repeatedly attempts to weaken consumer response to this professional hegemony in mental health care, which has taken the form of self-help and other lay alternatives. Attempts to equalize this relationship through incorporating the efforts of paraprofessionals and volunteers are being discounted, and the delimiting of expertise is clearly reinforced by the psychiatric community.

> The community 'helping' agencies should not attempt to establish clinics or psychiatric treatment services of their own. (More for the Mind, 1963, p.141)

More recently, the Report of the Mental Health Planning Survey (1979) emphasized the need to reaffirm "psychiatric leadership" which has been shifting to the domain of non-professional
workers in the field of mental health.

The interests of the professional are promoted through several channels. Regulating organizations such as the Royal College of Physicians or the Canadian Medical Association form perhaps the most cogent of these mechanisms. They are responsible for defining professional norms, protecting professional status and security, and generally promoting the interests of their members. They are entitled to blacklist members for inappropriate conduct, but also determine what constitutes such conduct (Blishen, 1969; Friedson, 1970a, 1970b; Illich, 1977). Also, organizational control over institutions and programs permits the maintenance of hierarchical structures beneficial to professionals. This tendency is overtly displayed in a report of the Core Committee for the reorganization of Riverview Hospital, where it is stated that in addition to certain managerial attributes of the model developed for Riverview, it should, in the future be seen that "in keeping with our terms of reference, professional concerns are safeguarded" (in Colls, 1976, p.104). In terms of the professional-client relationship, power may be exerted through information stratification, which provides potential for exploitation and control (Waitzkin and Waterman, 1974; Lorber, 1979).

The stance against a too active participation of the voluntary and lay sectors is equally apparent in recent documents. Govan (1966) reports the position of the Canadian Mental Health Association in the 1960's, which clearly states that the domain of the volunteer lies outside that of direct services to
patients, and that the voluntary sector fulfills a mainly philanthropic function. Recognition of the potentially innovative and therefore potentially threatening role of the non-professional sectors to mainstream professionals has also led to a diminution of some aspects of voluntary efforts. This is not surprising, since volunteer staffed or financed services provide not only a means for implementing unconventional ideas which may not find homage in government or professional agencies, but also perform a watchdog role on existing services (Carter, 1974).

Thus the medical professional may not be fully supportive of self-help ventures because they imply a critique of professional control of mental health care on two grounds: the hegemony of professionals over the definitions of mental health, and the power structure inherent in patient-physician relationships. Some authors, such as Waitzkin and Waterman (1974), McKinley (1979) or McKnight (1977) argue that the reluctance of the psychiatric community to accept this critique is based on upholding their status quo (i.e. present power relations) and the economies of not only their profession but of the service economy in general. While it is true that those economies are substantial¹, it seems more likely that physicians and clients alike are acting in a benevolent, non-conspiratorial manner, based on beliefs so firmly entrenched in our society.²

¹ In British Columbia alone, expenditures for total health services in the Ministry of Health for the fiscal year 1978/1979 amounted to $1,315,013,154.00 (Ministry of Health, 1979).
² Although some links between ideology and economic motives may be postulated.
Consider a statement by J.S. Bockoven, a prominent psychiatrist in the United States, which so clearly illustrates this professional ideology.

One might hazard a guess that if a time should ever arrive when physicians are regarded as no longer occupying the forefront of humanitarian leadership... (Bockoven, 1972, p.207, my emphasis)

This professional ideology is not only responsible for maintaining a hegemony of the physician in modern society, but also results in the perpetuation of the ideology itself.

He (the physician) is greatly dependent on an ideology with all its inevitable distortions of reality, to help resolve the emotional conflicts, the insecurity and doubts generated by the strains he feels in the performance of his role. But this dependence can only serve to intensify institutional resistance to change and thereby create more intense strains in the future. (Blishen, 1969, p.177)

Similarly, though, the patient's role is equally subject to subscribing to the professional ideology, which places the care-seeking individual in a subordinate position to the care-giver. Even in a self-help situation, where equal knowledge and power are stressed, individuals still tend to approach lay workers as "non-professional professionals", thus automatically assuming the patient role (Kleiber and Light, 1978). However, as Johnston (1972) warns, one should not assume that all individuals in society bear the same reified roles, nor that they are equally affected by them, but adds that they are nevertheless functional to the preservation of
an existing organization and distribution of power and the demise of a radical self-help movement in the social services.

What implications do these factors have for the effective implementation of self-help programs in mental health? It is clear, that there exists a need to return to a system not "captured by the market place in the guise of specialization, expertise and professionalism which need not have been lost by community institutions" (Wolpert, 1976, p.2). And in fact, there is ample evidence that many people are no longer accepting a condescending 'we know what is best for you' professional approach which may, as purported by some, allot a disproportionate share of the benefits derived from such treatment to the physician rather than the client (CELDIC, 1970). However, self-help in mental health may be particularly difficult to implement widely since this area has been professionally dominated for so many decades. A widespread utilization of paraprofessionals seems unlikely in the current, hierarchically structured system, for it seems inconceivable that psychiatrists and other mental health professionals who are wary of lay workers would refer patients to or support the activities of non-professional helping organizations (Chu and Trotter, 1974). And since self-help in many cases adheres to the rather austere criticism of the effectiveness of the practices of professionals, such as posed by Graziano (1972) or Rosenhan (1973), psychiatrists are not likely to uphold a movement which disputes their own beliefs. It is for these reasons that the role of the professional and the entire profes-
sional ethic must be considered as a significant component of any schema describing the effectiveness of the self-help movement.

THE COMMUNITY

The community component of this model differs from the two components discussed above, since it focusses more directly on vocal and active opposition to the physical location of mental health facilities as well as on community integration of former mental patients. The issue of locating facilities, such as group homes or drop-in centres does not apply to all types of self-help, nor is it inherent to the concept of self-help, since group homes (or other facilities) and self-help are conceptually distinct notions. However, when a self-help group establishes itself in the community in the form of an apartment or store-front drop-in centres, new avenues for opposition emerge. Many of the contentions raised may not relate to the issues involving self-help as such, but nevertheless create yet another barrier to the creation of a self-help alternative.

Community opposition to mental health centres is not an inherently spatial phenomenon, since in aspatial terms it is represented by an ideological adherence to the professionally dominated mode of health care, as well as broader attitudes toward mental illness. While these facets of community opposition shall not be explicitly discussed here, since they have been covered in the previous section, they do have a bearing on
the spatial opposition to self-help stemming from the community. In general, the community tends to support those notions of mental illness and treatment as defined by professionals. Therefore there also tends to be a tacit recognition that the 'best' alternative for the patient is the psychiatric institution and conventional treatment. This, of course, indicates less support for self-help from the community. Similarly, since patients are part of the community, they too tend to take on these expectations about illness and therapy. Patients themselves may often not support the self-help alternative. Thus the aspatial opposition to self-help may frequently emerge as spatial opposition to self-help facilities, especially if this is coupled with the many existing prejudices and fears about mental illness and the mentally ill.

Community resistance to the location of mental health facilities, and the consequent segregation of the mentally ill has been widely documented. Dear (1981) notes the historical tendency to segregate the mentally ill, whether in asylums or ghettos. This is representative of broader socio-spatial patterns, through which the segregation of 'unlike' groups occurs. In this manner, many neighbourhoods remain relatively free of facilities and a proliferation of ex-mental patients, while a few others become saturated (Wolpert, 1976; Dear, 1977, 1981). This outright rejection of the mentally ill is usually based on grounds of tangible and intangible threats they may pose (for example, decreased property values or increased traffic, and fear of personal safety, respectively) but it is
broadly generated by more general attitudes about mental illness which still prevail in our society (Dear and Wittman, 1980). The mechanisms through which these fears are mediated are varied. Dear (1977) describes a rather vague notion of "spatial filtering" through which ex-mental patients and their corresponding facilities and services gravitate toward specific areas, usually inner cities, but in a later paper (1981) is more explicit with respect to these filtering strategies, describing them as a two-fold process. On the one hand, the "power of socio-spatial exclusion" operates either formally by preventing the location of facilities through zoning ordinances and political lobbying, or informally by psychological or physical abuse of clients or facilities. This description corresponds very closely to those 'formal' and 'informal' processes of spatial segregation described by Segal and Aviram (1978). On the other hand, in many cases the state exercises its control through planning policies thereby affecting those neighbourhoods with a lesser degree of political clout. Least risk zoning policies, for example, are frequently instrumental in restricting mental health facilities from some neighbourhoods while consequently saturating others (Dear and Taylor, 1979).

Findings in the literature suggest that neighbourhood characteristics, such as socio-economic status, predispose individuals to certain attitudes toward mental illness and therefore act as 'precursors' to either receptiveness or opposition to community-based mental health facilities (Hollingshead and Redlich, 1958; Dohnenward and Chin Shong, 1967;
However, it may be more likely that decisions governing the location of controversial facilities are directly reflective of power in the community, thereby differentiating between those where there is insufficient awareness for opposition to arise, those whose opposition may be ignored, and those who must be placated (Mumphrey, et al., 1971). This framework may explain the under or non-allocation of facilities in areas where greater opposition may be anticipated.

At least to some extent, there does exist some opposition to the introduction of community based residential care facilities in Vancouver. In fact, the location of two group homes in the Kerrisdale and Hastings-Sunrise areas of Vancouver have been opposed by the community and consequently rejected (Vancouver Sun, November 18, 1981).

Thus it is clear that mental health facilities, in any form are considered to be 'noxious', or posing significant negative externality effects. Smith and Hanham (1981), for example, show that mental health facilities were judged to be the most noxious of all such facilities by their sample of Oklahoma college students, although facilities of greater scale (e.g. institutions) definitely evoked higher ratings of undesirability. As they point out, it is essential for facilities such as half-way houses to be able to locate in accepting neighbourhoods, but at the same time they are frequently faced with less than optimal locations due to community opposition which frequently cannot be overcome.

In this same paper, it is suggested that by rendering
facilities less visible, (for example, by manipulating their physical form or by locating them in shopping centres) loca-tional conflicts would become less prominent. However, it seems that often small scale facilities are already inconspicuous, and in many cases virtually indistinguishable from other residential dwellings or store-front facilities. In fact, from data collected in Toronto, Ontario, it was demonstrated that although 133 respondents "aware of a facility in their neighbourhood" (of a total of 384 residing in a neighbourhood with a community mental health facility), only 33 respondents could name or locate the mental health facility, while 69 reported facilities in other neighbourhoods, believing them to be the closest to their homes (Pulcins, 1980; Dear and Taylor, 1982). Thus opposition to such facilities transcends the mere degree of physical intrusiveness, and is reflective of the segregation of the mentally ill and, perhaps, other 'unlike' groups as well. As Fincher (1978) suggests, the labelling of such community based facilities as being exclusively for groups such as former mental patients automatically deems them as different (although they are not classified as requiring institutionalization any longer) and therefore unacceptable to the communities involved.

However, recent findings strongly support the potentially positive role of the community as a coping or support network, especially with respect to mutual aid for groups such as former mental patients or people generally seeking some type of support through difficult experiences. Smith (1980a) even
goes so far as suggesting that such networks constitute "theoretical counterparts" to the more formalized self-help, or mutual aid movement. For Smith, the importance of accessible community networks to the former mental patient, who is, in a sense new to the community, is clear, since they tend to primarily interact on a single stranded basis. They might converse with one person, seek help from another and ask a third for a small favour. Typically they relate to each other as if they were 'familiar strangers' standing on the platform of a railroad station. For one reason or another they have difficulty locating close contacts from whom they can solicit different types of support. (Smith, 1980a, p. 514)

Thus the importance of living in an accepting community cannot be underestimated. Informal networks, either as 'helping networks' or quasi-institutional groups (such as self-help groups) both function, in addition to the formal modes of help found in cities, in aiding individuals. This occurs even though such networks or groups may often seem invisible or remain unnamed (Smith, 1978). Neighbourhood networks in a general sense may help individuals cope with day to day problems or serve to inform them about facilities or resources not located in the immediate area, which they would otherwise be unaware of (Smith, 1980b). A multiplicity of helping ties may thus be indirectly established even though primary ties may be weak (Wellman, 1979). And since most community based supports are not family based (Trute and Segal, 1976), spatial proximity between contacts that neighbourhood networks could potentially provide may be relatively important (Wellman, et al.,
especially for former mental patients who may not be especially mobile. The importance of friendship or contact groups in a variety of contexts has also been recognized as a protective environment (see, for example, Finiter, 1979, with respect to political deviancy).

Whether or not the community itself is prepared to offer the mentally ill the benefits of such networks remains an unresolved question. Chu and Trotter (1974) point out that although the community mental health ideology may have had a major effect on increased efforts to place care-giving in the hands of the community, many former mental patients entered the community to find antagonism and hostility instead of aid. In conclusion, two opposing forces may be witnessed with respect to the question of the community. On the one hand, the significance of community ties and the need for non-professionally administered 'help', either informally or through self-help groups, is acknowledged. However, it appears that some types of communities, at least, are not ready or willing to accept the mentally ill on either a formal or informal capacity. This constitutes a major barrier to the existence of non-professional services, since coping with day to day problems implies interaction with, and acceptance from, the community.

SECONDARY LINKS

In addition to the primary, or direct links to the outcome of the self-help movement discussed above, various secondary, or indirect links may also be observed. The first of
these secondary links is the interaction between the professional community and the state. Mental health professionals are active participants in policy formulation in many ways. Perhaps the most obvious of these, and that which should be of concern here, is the dominance of mental health professionals in state policy bodies. The preponderance of psychiatrists and psychologists in the upper echelon of the Mental Health Branch of the Ministry of Health in British Columbia provides one such example. However it must be noted that these professionals are now starting to be replaced by health care 'managers', who are assuming these positions. Of course it is only reasonable, and even necessary that matters of mental health should be in the hands of those who, supposedly, have the highest level of expertise in this particular field, but at the same time this channels policy uni-directionally back into the professional arena. Provincial policy in British Columbia, for example, places the role of self-help merely as that of a low level feeder to higher (i.e. professional) levels of care (Priority Programs in Mental Health, 1979). Accordingly, Chu and Trotter (1974) note more generally the effects of professionally dominated policy formulation which may result in avoidance of funding programs which do not fall within the professional model or the manipulation of patient careers exclusively from one level of professional care (e.g. institutions) to another (e.g. boarding homes). Thus state policy and the professional community are not mutually exclusive, nor even easily distinguishable forces. Lacking constructive input from con-
ventionally unrecognized sources of aid (such as the self-help movement) policy is moulded by and reflected back upon the professional, creating very limited types of programs for mental health care.

Secondly, some policy issues are similarly influenced by the community. As discussed in the previous section, community resistance to mental health facilities has a defining role in local planning policy, as well as at a more centralized level with respect to defining the terms and regulations of community based mental health facilities, such as transition houses. In turn, such regulations maintain the segregated character of some neighbourhoods which are able to remain facility-free, thereby perpetuating the social and spatial isolation of the mentally ill and other unlike groups (Dear and Wittman, 1980; Dear, 1981).

The interaction between the community and the professionals constitutes the last, and perhaps vaguest link to be considered. Again, an attempt to delineate boundaries between the two is tenuous, since the two are mutually reinforcing. On a broad scale, the professional ethic, or ideology of health care is upheld by the professional and community alike. Adherence to the roles of 'patient' and 'physician' obviously acts as a block to the demise of this care-giving pattern. On a more specific level, community or voluntary organizations may uphold professional interests while acting in the interest of, for example, mental health care. Or, since volunteer or community groups are often accountable to
one funding source or another, they may tend to prop up the interests of economically more advantaged groups. Thus, intentionally or unintentionally, community organizations may serve as organizational vehicles for professionals or other groups (Gilbert and Specht, 1974).

It is apparent, then, that the three components in this model exercise control over the implementation of the self-help model, through indirect as well as direct links. In this sense it is important not to place the onus of the outcome of the self-help movement exclusively on the professional, the state, or the community. They represent mutually reinforcing sectors, rooted in an ideology which drives, as much as it is driven by, the preservation of the status quo.

OUTCOME

A need for a self-help alternative to mental health care, at least by a certain segment of society, has certainly been recognized on several grounds. The ineffectiveness of the private and public sectors involved with health care demands the restoration of donor or community based coping networks (Wolpert, 1976). Others "no longer accept an arrogant 'we know what is best for you' professional who defines human need and meets it in a way designed to enhance his own status and authority" (CELDIC, 1970, p.329). The necessary 'non-publicity' given to the locations of transition houses in the Vancouver area attests to the great demand and limited supply of such services at the present time.
The evidence suggests that self-help groups may not, in practice, function as originally intended, since the vested interests of those involved may contradict the goals of radical alternatives (Chu and Trotter, 1974). Thus the outcome may take one of many forms. An organization, for example, may become increasingly conservative due to policies which view funding as direct payment for services. Therefore these services may begin to resemble commodities (Fincher and Ruddick, 1983; Wilson, 1973). Or, under the guise of restoring self-control to psychiatric patients, programs directed to the client may actually serve the purpose of expanding the domain of the professional (Chu and Trotter, 1974). It is equally possible, that misguided attempts to incorporate self-help in the mental health system due to fiscal conservatism in times of crisis, rather than to ideological commitment, may result in the replacement of professional for volunteer or lay workers, and a more extreme form of class stratification where only the rich would receive professional attention (Gartner and Riessman, 1977).

Various types of cooptation may also occur. Perhaps the funding issue, discussed in a previous section presents the most onerous of these. Funding may pose less of a problem in the initial stages of a movement, where voluntary monetary contributions represent a commitment to, or support of the organization's cause or ideological basis, but later as the organization becomes increasingly institutionalized, funding is often viewed as direct payment for services rendered. This
stage usually signifies a tendency toward conservatism in the organization (Wilson, 1973).

Secondly, increased institutionalization may result in cooptation as well. It is seemingly inevitable, that as an organization expands in scope and influence, it also becomes increasingly institutionalized. In order to cope with the administrative tasks such centrifugal growth demands, a structured delegation of activities and responsibility is called for. While on the one hand structural differentiation represents the only route to increasing power and influence, on the other hand this type of functional stratification leads to a power structure resembling the very institutions to which these organizations (such as self-help) are attempting to provide alternatives. Similarly, to occupy a position within those organizations implies an acceptance of them. In both cases, there exists the possibility of cooptation (Wilson, 1973). One can easily envisage examples of both these situations in the mental health self-help movement. Although self-help groups usually strive to function within a non-stratified, egalitarian structure, centrifugal expansion creates a situation where a governing elite becomes essential. Similarly, attempts to exert influence over mental health care delivery within a broader schema, such as through representation in the Canadian Mental Health Association, poses similar problems. Both situations imply a diffusion of the movement into mainstream practices, and therefore cooptation.

Thirdly, cooptation may result from outside profes-
sionals attempting to establish jurisdiction over certain issues. Although such attempts may prove to be beneficial, they may also have the converse effect of depoliticizing the issue at hand by treating it as an essentially medical, internal matter. Clearly, all three cases of possible cooptation stem from the inherent paradoxes of the evolution of self-help: gaining power necessitates legitimization, which in turn undermines the principle of activism they represent.

In addition to the external barriers facing self-help (as discussed throughout this section), internal barriers present within the groups themselves may represent additional barriers to successful action. In this respect Schur (1980) cites several hurdles which must be overcome, including "attempts to preserve group cohesiveness, maintain high morale and commitment, and impose necessary coordination" (Schur, 1980, p.201). Again, due to the very nature of social movements, each of these hurdles may become problematic. As the group becomes stronger in number, the potential for internal conflict increases accordingly, since interpersonal contact and other informal mechanisms ensuring group solidarity become replaced by depersonalized rules and markedly rigid structures (Wilson, 1973). A corresponding move toward bureaucracy and hierarchical rule occurs, which may in fact be damaging to the movement.

Among conservative movements which do not find the idea of an elite uncongenial, this tendency is to be expected, but Michels found it to be the rule even in the very bosom of revolutionary parties. Certainly, the impulse is very strong. (Wilson, 1973, p.11).
Another barrier lies hidden in the group's need to rally support and consciousness with respect to a common cause. Unfortunately, "since social inequality in health is not as visible as other inequities, health is still interpreted by consumers in individual rather than sociopolitical terms" (Riska and Taylor, 1979, p.360). In fact, a substantial, if not major proportion of consumers are not even aware of potential strategies toward a system of health care delivery which would maximize consumer power and input (ibid.).

A different type of problem facing organizations such as self-help movements concerns the multiplicity of goals with either between group members or various specific groups. Although Schur (1980) notes that a diversity of interests serves as a positive factor because of resultant diffusion of conflict between groups due to this multiplicity, at the same time, a cooperative effort between groups may be undermined by internal divisions, or factioning. While broader, less specific movements have a higher propensity to make a significant impact on social change, they are also more prone to factional splits than smaller, more specific movements (such as those concerned solely with the rights of the mentally ill, for example).

In this sense, Ley (1974) shares a similar observation. If the internal environment of a group is fractured so that goals are not shared by all participants, the absense of a 'united' sense of action results. Subsequently, the direction taken by the group may be inappropriate to the original
goals. If this occurs,

Energy is expanded solely on the maintenance of the groups, on confrontation with potential allies, on internal disputes. The group has centred a state of idolatry, of self-seeking gratification.
(Ley, 1974, p.81)

Therefore, such factioning not only undermines a cooperative effort, as noted above, but turns the groups into a state of introversion and significantly weakens the groups' ability to attain goals and resist opposition.

Lastly, status inconsistencies stemming from differentially stigmatizing ascribed status, compounded by social, economic and political differences within each category of stigmatized individuals, produce a plethora of goals and level of commitment among participants. "It cannot simply be assumed that all former mental patients ... will share a common sense of purpose or display an equal indignation and motivation to act collectively" (Schur, 1980, p.208). In a similar fashion, non-participant supporters (i.e. those who are not directly affected, but offer support) may be characterized by status inconsistencies differentiated on the basis of, for example, class, ethnicity or gender (Schur, 1980).

As Wilson points out, social movements are dynamic due to their inherent element of change. If the barriers outlined above can be overcome, social change may be successfully implemented. However, they often become insurmountable, in which case the movements lose momentum and eventually dissolve. In some cases, a general weariness, a fatalism concerning
defeat, and harassment cause activists to "give up without actually dropping out" (Wilson, 1978, p.21). Commitment and energy wanes, as members face obstacles and, individual self interest takes over, a sometimes inevitable fact due to societal preoccupation with the 'private good' (Lemon, 1978). Thus the organization per se, remains active but usually becomes increasingly service oriented and conservative. Or, the movement can continue in a quest for self-preservation, whereby original goals are relegated to a back seat position in favour of maintaining internal consensus and the satisfaction gained from the activities themselves. Idolatry, as Ley (1974) points out, when leading to a situation of internal status seeking and alliances, may result in a situation where the group continues regardless of the decreasing (or lost) importance of goals, being fed solely by the emotional and social rewards reaped. But yet other groups are immobilized by a stalemate situation. In either case, the group may become institutionalized, whereby the groups become accepted as mainstream organizations. Finally, they may fail completely and disappear.

Therefore, the self-help movement and their critique of the professional hegemony in the health care system and the counterproductive results rendered by them, including dependency on medical experts and the mystification of clients about their own conditions may or may not succeed in their existence or in bringing about institutional change. Such movements face both external barriers and internal barriers, which may lead to
a shift in their original goals or a loss in momentum and eventual dissolution. On the other hand, success may be equally possible, although a full attainment of such a goal requires widespread consumer participation and possible political mobilization (Gartner and Riessman, 1974). The task now is to evaluate the outcome of the activities of self-help groups in Vancouver.
CHAPTER THREE
RESEARCH DESIGN

In this chapter the research design of the study is discussed. Firstly, the type of design, and the rationale behind its selection, are described. In this context, the variety of specific methodologies used, including several questionnaire and interview approaches as well as documentary sources, is outlined. Finally, the analytical framework and application of the data to the model are considered.

RESEARCH DESIGN

As noted in the previous chapter, a variety of elements are material to a full understanding of the implementation of a self-help mode of care giving. These include not only the initial formulation after which the concept is modelled, and the practical outcome, but also several intervening factors, including the community, the professional ethic and the state. The proposed model, which incorporates each of these elements, (as outlined in detail in Chapter Two) serves as the basis for the research design discussed here.

Reflecting the comprehensive nature of the research material, the twofold research question which emerges is also of a broader, rather than very specific, orientation. Firstly, it is the object of this study to identify, and more importantly, assess the impact of community, professional and governmental influence in establishing a self-help system of care. Secondly,
it is a goal of this study to establish the 'outcome', or the current operationalized state of such groups in comparison with their original formulations.

Research questions of this type hold obvious implications for the development of an appropriate research design, which must be able to take into account a wide array of factors and data to produce a general overview of a complexity of components, while yielding reliable and valid results. Thus, the use of a variety of research formats has been deemed most appropriate for a study of this scope. The complexity of the model as well as the inappropriateness, in this case, of identifying very specific and highly structured research questions, warrants approaching the problem from several sources and angles. Among the formats utilized, are several interviewing and questionnaire techniques as well as the use of documentary sources. These will be discussed in detail below.

The use of these formats renders an analysis which is not a particularly structured one. This has proven to be beneficial for several reasons. Firstly, the rather broad scope of factors under investigation can be adequately researched only with the aid of tools which reflect this latitude. In this manner, the proposed model of the operationalization of a self-help mode of care-giving can be investigated to produce a coherent and holistic understanding of the processes of implementing new structures and models.

Secondly, the qualitative nature of most of the data is equally an asset. While quantification of data and
structured analyses do offer advantages of very concrete and definitive relationships between variables, as well as offering the luxury of demonstrating statistical significance in many cases, one may run the risk of bypassing many more subtle yet important findings that cannot be readily identified utilizing only a statistical analysis. Furthermore, by avoiding the use of multivariate techniques, the risk of superimposing artificial constructs on the data is lessened significantly. The manipulation of qualitative data discloses nuances and subtleties that may remain hidden (or lost) if reduced to simple numerical relationships.

Thirdly, the variety of sources which are considered add much to both the validity and reliability of the findings. Each format and data type consistently act as cross checks and verifiers of the data. Furthermore, discrepancies found between various sources are able to uncover and enhance many of the conflicts inevitably associated with processes such as those characterized by the model.

Following is a detailed account of the sample definition, and descriptions of the major data collection methodologies utilized in this study. These include two separate interviewing campaigns, a structured questionnaire, documentary sources, and the use of development permit files.

SAMPLE SELECTION

The elucidation of the concepts 'self-help' and 'mental health' was vital to the identification of the sample
of mental health related, self-help groups within this study. Since both terms tend to be used widely, and carry with them a rather broad and therefore imprecise range of interpretations, clarification was essential before a selection process could commence.

The essential components of self-help groups to be included in this study have been elicited from Owen's (1978) comprehensive definition of self-help (see Chapter One, p.19). To qualify as self-help groups in the present context, they must:

(i) operate on the principles of mutual aid and support;
(ii) be voluntary in nature;
(iii) try to fulfill a need not met by existing structures or institutions; and
(iv) focus on power reversal in operating within a non-hierarchical structure.

On the other hand, the characteristics of the groups falling within the jurisdiction of the term 'mental health' are less tangible. This is due to the non-acceptance of the traditional medical model of illness by the self-help movement (as it is defined within this study), which demands a widening of this category beyond the mere consideration of individuals who have been diagnosed and are under treatment for a psychiatric disorder. Thus in keeping with this broadening

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1 The term 'medical model' refers to that concept of illness currently accepted by the mainstream medical community, and may be most simply characterized as the sequence of defining the illness, isolating and executing treatment for the specific disorder. This concept tends to preclude disorders which have not yet surfaced to the point of detection, as well as effects following recuperation.
of the concepts of mental health and illness, the definition used here shall encompass prevention (i.e. dealing with day-to-day personal crises) and health maintenance of individuals who have suffered from mental illness or stress-related disturbances in addition to those labelled as 'mentally ill' by the psychiatric profession. Therefore, some family groups and women's crisis centres, whose primary purpose is not mental health, yet who themselves acknowledge their important role in the maintenance of mental health are included as well as self-help groups specifically formed for ex-mental patients and those currently undergoing psychiatric treatment.

With these definitions carefully elucidated, the task of identifying the sample was completed in two stages. During the first of these stages, the geographical limits for sampling, and the sampling method were defined. With respect to the former consideration, it was concluded that the Vancouver Metropolitan area would provide a manageable target, in terms of establishing contacts with the groups, and still provide a sample of sufficient size. The resultant sampling frame was a definitive factor in establishing the sample type. Since groups could only be drawn from the Vancouver area (and this does not yield a great number of groups), the entire population of mental health related self-help groups was considered.

In an attempt to identify all groups of this nature within the specified target area, a number of sources were consulted. Typical sources included community newspapers, service agencies and social service directories. However, a
comprehensive and up to date file organized by the Vancouver Information and Referral Services provided an excellent list of service organizations. Those groups conforming to the guidelines outlined above were then extracted from the master list.

The second stage involved a more thorough screening of the preliminary list, warranting clarification of the aims and activities of many groups. A number of groups were eliminated from the sample if their foci or principles did not conform to the sample criteria. Sixteen groups were identified as following the principles of self-help, five of which deal specifically with individuals who have at one time been hospitalized in a psychiatric institution or received some form of psychiatric counselling.

RESEARCH METHODS

As stated above, a variety of research methods were utilized in order to elicit a rich, relatively unstructured data base. The five principle methods, their purpose and execution in relation to the model are discussed below.

Interviews (I)

Perhaps the most valuable source of data may be found in the set of interviews conducted with the coordinators of the self-help groups identified as the sample. Although these were designed as open-ended, unstructured interviews, in order to yield the maximum amount of information possible, each was bounded by a set of skeletal questions (Appendix III).
This ensured that all relevant topics would be addressed at some point during the course of the interviews.

Briefly, six major topics were addressed in the interview outline. Group officers were first queried about the general operations of their self-help organizations, with particular emphasis on their philosophical base. Data pertaining to their philosophical orientation was elicited directly or indirectly (by soliciting information about membership criteria or services they feel are important to provide) (Part A). Part B of the questionnaire was included to determine the degree to which they conform to the definition of self-help used in this study. Specifically, these concerns included organizational structure (e.g. patient run, democratic), their stance toward professionals and the mutual support function as a major focus of their operation. Considerable emphasis was placed on funding, and the problems, constraints or advantages derived from the funding sources (Part C). Also, questions relating to their physical location in the community, their perceived and desired levels of visibility in the community, as well as zoning regulations were included in Part D. The groups' identification with the self-help movement, the extent of tangible ties with it and the political awareness of group members were investigated in Part D. Finally, group officers were asked to assess their ability to fulfill their goals, and the manner in which these goals may have changed. Furthermore, their effectiveness on instilling change upon patterns of health care delivery was queried. In
conclusion, respondents were given the opportunity to offer concluding remarks (Part F).

All interviews (with the exception of one which had to be conducted over the telephone out of necessity, at the request of the group coordinator) were taped, thus creating a more relaxed atmosphere and guaranteeing accuracy in the recording of information. The duration of the interviews was approximately one hour, although, predictably, there was significant variation depending primarily on the rather hectic schedules of the respondents.

Interviews (II)

A second set of unstructured interviews was conducted with physicians actively working in the field. The sample in this case was limited, since the purpose was not to canvass the opinions of medical professionals in the area in general, but rather to elicit prototypical points of view about self-help from various types of medical practitioners. Therefore, a disproportionate purposive sample was utilized. Physicians representing different medical schools of thought (as identified by their peers) including family practice physicians, medical model advocates and health promotion practitioners were approached. The sample was disproportionate since although each faction was represented relatively equally in this sample, this is not typical of the actual distribution of physicians (who tend to correspond overwhelmingly to the 'medical model' faction). Eight physicians were interviewed in an open-ended, unstructured manner. Unlike the first set of interviews, it
was found that keeping a written record was more appropriate to this particular situation and therefore no tape recorder was used.

**Questionnaire**

In order to obtain a response from the users of a self-help group, the members of the Mental Patients' Association, perhaps the most prototypical, and one of the first self-help groups established in the Vancouver area were requested to complete questionnaires (Appendix IV). Although a wider response could have been realized through a canvassing of members in a larger number of self-help groups, it was felt that comparability of results could not be achieved in this manner. The questionnaire (to be filled out by each respondent and then returned) was designed with the intention that it could be completed with a minimum of writing, by utilizing check marks, and short phrases as much as possible. Yet at the same time, it was important to allow respondents to give more complete responses if they wished and were able to do so. Two open ended questions were included at the end of the questionnaire, to ensure that all areas would be adequately covered and also to compensate for the structured bulk of the questionnaire. The effort to design such a questionnaire was especially warranted in this situation, since many of the members, whom it was important not to preclude from responding, possessed a minimal amount of reading and writing skills, either due to limited educational backgrounds or medication induced impediments.
The questionnaire was intended to elicit data in several areas. Referral networks and sources of information about the MPA (informal contacts, advertisements or professionals) were investigated in two introductory questions. Several questions (3, 4, 6, 9, 11) were included to assess member awareness of the self-help philosophy and function of the MPA. The duration and frequency of the respondents’ participation in this association were targeted in questions 5, 7, and 8. Client assessment of the MPA generally (questions 9-10), and of the impact of self-help on recidivism and recovery (questions 12-13) represented important issues in this survey. Questions 14-16 considered the levels of political awareness and awareness of the existence of a broader self-help movement among MPA members. Lastly, respondents were able to comment generally on the psychiatric system, the MPA, or other relevant issues (questions 17-18).

The questionnaire was pretested and found to work very well. No changes were made except in the addition of a 'not applicable' category in one of the questions. Also, because of the particularly closed and somewhat guarded atmosphere within the Mental Patients' Association, several recruiting visits were necessary to rally support, and in this manner, encourage members to participate in the completion of the questionnaires.

Approximately one hundred questionnaires were distributed to the MPA drop-in centre as well as to their boarding houses and apartment. Forty-one completed questionnaires were
returned over a period of three weeks, thus resulting in a forty per cent completion rate. However, two could not be incorporated into the sample due to the inappropriateness of the responses. The final sample included thirty-nine completed questionnaires, many of which yielded lengthy comments on various aspects of the questionnaire, self-help, psychiatry and so on, in response to the open-ended questions included for this purpose.

**Documentary Sources**

In addition to the direct techniques employed, a wide array of documentary sources was consulted. These included annual reports (of government ministries, for example), newsletters and reports from self-help groups and the self-help movement, newspapers, and where available, government policy statements. In this manner, material representing all facets depicted in the model (the community, the professional community, the state and the self-help movement) was uncovered.

**Development Permit Files**

An enquiry into the history of development permit files (development permits and the related documents which often accompany attempts to obtain them) applied for by mental health related self-help groups in the Vancouver area was conducted to reveal both the extent of community opposition to such facilities and the response of municipal planning authorities to their introduction into city neighbourhoods. In conjunction with this investigation, city planning officials were also consulted to clarify many issues which appeared in
the development files, thereby revealing much information that would otherwise not be apparent from the files themselves.

The combination of data elicited from the above mentioned sources was applied to each facet of the model (see Figure 1). It should be noted, that each method elicits data concerning several of the model elements, thereby ensuring that each element in the model would not be investigated through entirely separate methodologies (Table I). The results of the analysis of the data are reported in the following chapters.

SUMMARY

An array of research frames was chosen, not only because a variety of methods was deemed most suitable to the model, but also because the resultant richness of the data collected added assurances concerning the validity of the results. These included two sets of interviews, a questionnaire, the use of development permit files and documentary sources. The analysis of the collected data is of qualitative rather than quantitative form. Several reasons are cited for the adoption of such an approach. Finally, the application of the various data collection methods to the model are demonstrated briefly.
### TABLE I

APPLICATION OF DATA TYPES TO MODEL

<table>
<thead>
<tr>
<th></th>
<th>Interview I</th>
<th>Interview II</th>
<th>Questionnaire</th>
<th>Documents</th>
<th>Devel. Permits</th>
</tr>
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<tbody>
<tr>
<td>The State</td>
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<td></td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Professional Ethic</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Community</td>
<td>*</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td>*</td>
<td></td>
<td>*</td>
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<td>*</td>
</tr>
</tbody>
</table>
CHAPTER FOUR
THE ROLE OF PROFESSIONALS, PUBLIC POLICY,
AND THE COMMUNITY IN SELF-HELP:
A VANCOUVER CASE STUDY

An evaluation of operationalizing self-help from a conceptual state to a fully working alternative must encompass two considerations; the effect of barriers such groups may face in attempting to establish themselves, and the actual outcome vis à vis their effectiveness as judged by self-help clients and coordinators. In this chapter, this first consideration shall be discussed, focussing on self-help groups specifically concerned with mental health in the Vancouver area.

As already outlined in the basic model of the operationalization of self-help groups (Chapter Two) the hypothesized links between self-help and 'outside' barriers are threefold, including as integral components public policy, the medical professionals and the community. The present chapter will attempt to link each of these to the Vancouver self-help experience.

It is important to note, that this research represents a study of a small sample of self-help groups, since the definition of self-help laid out at the outset of this work was strictly adhered to. This facilitated a sampling of several self-help groups, all located in the immediate Vancouver area, sharing very similar (i) internal structures, (ii) client groups and (iii) philosophies about particular non-medical paradigms in which to bring about well-being for the individual,
and also broader changes in the medical, and perhaps, social arena. The final sampling, therefore, was limited to ten self-help groups in Vancouver, which rigidly conformed to the definition given here.

This small sample, however, does seem to mirror a larger, more major shift in both medical paradigms and social service delivery, and the data reflect this. In perhaps the same manner that self-help groups are couched in a 'no man's land' of service provision, belonging neither to any of the mainstream systems nor any at the forefront of service delivery, their relationship with those elements mentioned above - public policy, the medical professionals and the community - are more often than not equally elusive. Herein lies the key to a thorough understanding of the Vancouver case study. Since this is not a body of data which can be extracted from policy statements, or other documents (in most cases the issue simply has not been addressed), a more subtle data base is indicated.

SELF-HELP VERSUS THE MEDICAL PROFESSIONAL

The issue of medical professionals and the barriers they may pose for the successful operationalization of the self-help mode is perhaps the most tenuous, and certainly the most elusive to attempt to isolate. The reasons are varied. While it has been demonstrated, in previous chapters, that there probably exists, among medical professionals, a 'non-acknowledgement' of self-help as a viable alternative within our
health care system, it can also be demonstrated that on the whole little has been done by self-help groups to educate, and even less to incorporate, physicians into self-help.

On this, most basic level, it is necessary to point out that to assert the 'self-help' and sometimes anti-professional stance of the groups, medical professionals are not granted entry into the self-help venture. No officer of any self-help group included in this study could cite any interaction they may have had with medical professionals in terms of, for example, information dissemination, and all were vague about any interaction, past or present. Of course, professionals are never considered in a treatment capacity, thereby reflecting the self-help allegiance to maximizing information and independence for their clients by working outside the professional arena. Typical reasons include the view that "the traditional stance and viewpoint are not beneficial in this situation" and that "they (medical professionals) maintain a typical dependency creating model" (self-help agency coordinator). However, officers from two of the ten self-help groups did mention calling upon professionals from time to time, but more careful scrutiny uncovered that they included day care workers, social workers, or family counsellors, but never, for example, psychiatrists, in this capacity. In one additional case, one officer is "sometimes forced to refer them back, but there is no dialogue".

This action of isolating themselves from the professional community is a direct result of the anti-self-help
stance perceived to characterize the medical profession. In those cases where the self-help groups focus directly on services for ex-mental patients exclusively, these anti-psychiatric prejudices are derived from the experiences of the clients themselves. In the questionnaire returned by 39 members of the Mental Patients' Association (MPA), respondents were asked open-ended questions to grant them an opportunity to express any views about the MPA, psychiatry, the questionnaire, and so on. Not surprisingly, all but seven (17.9%) respondents volunteered opinions about psychiatrists or the therapy rendered. Twenty respondents (51.3%) volunteered remarks concerning ineffective approaches and control of patients by psychiatrists in conventional therapy. Eight (20.5%) raised the issue of human rights for patients under psychiatric care and another four (10.3%) expressed a general distrust of the psychiatric profession. (Several respondents expressed views applicable to more than one of these general categories.) The anti-psychiatric climate within the MPA is clear:

Under the auspice (psychiatric treatment), they (psychiatrists) feel it is correct to saturate your head with pills, injections, electro-shock, etc. Sometimes it almost seems like they need mental patients to keep their jobs. (MPA client)

Psychiatrists should realize that the medical model does not fit the majority of mental patients. (MPA client)

Perhaps it is appropriate to acknowledge that most professionals would not be accepted into the self-help arena, in this way diminishing the role the professional community
plays as a barrier to the effective functioning of self-help. On the other hand, officers of the self-help groups did perceive an equally distrusting attitude among the professionals toward self-help, and furthermore, they maintain that the professional community does indeed pose a possible barrier. The result is a stance quite paradoxical to the functioning of the mainstream service industry: an acknowledgement of the aid and support self-help can give, as well as a stamp of approval is desired by the self-help movement, while at the same time maintaining an independent, non-medical manner of operation.

Ideally, these seemingly contrasting notions need not be incongruous, and self-help services could potentially be viewed as auxiliary, non-conflicting services. To what point is the professional community acting as a barrier to self-help? On an overt level, there is little evidence of such action. In terms of policy statements, medical editorials or the addressing of self-help (pro or con) in medical publications, such anti-self-help action is not evident. What may be witnessed, however, is an overall ignoring of self-help in private and institutional practice. This is viewed as a barrier itself.

One measure of any tangible support for self-help may be the extent to which physicians refer their clients to self-help instead of keeping them under their own wing. However, in no case was an officer of a self-help group aware that such referrals were, indeed, occurring. The survey of MPA clients revealed the same trend. Of the 39 respondents, not one was
made aware of the self-help group by a psychiatrist or physician (Table II). With the exception of three members who had been told about the MPA from social workers, others had to rely on less formal sources of information. Even in the case where a client heard of the MPA from a notice board at Riverview Hospital, the provincial mental institution, it is known that MPA members themselves place these notices, not professional staff. Similarly, the reasons many cited as their original impetus to start frequenting the MPA drop-in centre included only one referral, again by a social worker (Table III). Thus it is clear, that at least in the case of the Vancouver based groups, an active support of self-help groups vis à vis referral to them or even advising patients of their existence by psychiatric professionals does not occur.

In order to gain a more complete understanding of the general attitudes of the medical community, a brief canvassing of professionals was conducted. It must be stressed that this was not meant to be an exhaustive polling of physicians, rather, a survey of a carefully selected group of eight health care professionals. This group was selected in order to represent the spectrum of current medical approaches, and included one 'conventional' psychiatrist, one psychologist, three family practitioners, two health promotion representatives and one lecturer and researcher. All have been trained in conventional medical teaching institutions, while some also had additional training (such as academic training at the doctoral level). The labels associated with the above professionals
### TABLE II

**SOURCES OF INFORMATION ABOUT THE MENTAL PATIENT'S ASSOCIATION**

<table>
<thead>
<tr>
<th>Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>27 (69.2%)</td>
</tr>
<tr>
<td>Physicians</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>3 (7.7%)</td>
</tr>
<tr>
<td>Magazine/Newspaper</td>
<td>3 (7.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>6 (15.4%)</td>
</tr>
<tr>
<td>Passed by MPA</td>
<td>4</td>
</tr>
<tr>
<td>Notice at Riverview</td>
<td>1</td>
</tr>
<tr>
<td>Vista Boarding House</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong> (100%)*</td>
</tr>
</tbody>
</table>

* Rounding error
<table>
<thead>
<tr>
<th>Reason for initial visit</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacts at the MPA</td>
<td>9 (23.1%)</td>
</tr>
<tr>
<td>Referred by social worker</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>Dropped by the MPA centre</td>
<td>24 (61.5%)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (12.8%)</td>
</tr>
<tr>
<td>Needed help</td>
<td>3</td>
</tr>
<tr>
<td>To find employment</td>
<td>1</td>
</tr>
<tr>
<td>To work for the MPA</td>
<td>1</td>
</tr>
<tr>
<td>No other place to go</td>
<td>1</td>
</tr>
</tbody>
</table>
| Total                                   | 39 (100%)*

* Rounding error
were agreed upon by individuals in the health care field, who are familiar with current trends and the professionals associated with these various schools of thought.

Instead of querying each practitioner on his own personal approach, it was felt that a more appropriate manner in which to conduct the interviews would be to pose questions concerning their views of the perceptions of the medical community concerning self-help. Perhaps not surprisingly, in almost all cases it proved difficult to hold the respondent to the topic of self-help. Moreover, most were very poorly informed, and some dismissed the topic altogether. The task of grouping these respondents into four basic categories was not a difficult one. Two respondents did not acknowledge self-help as an existing alternative. This attitude is accurately expressed in one respondent's summation: "I know nothing about self-help. I don't even have any prejudices about it."
The second group (one respondent) definitely expressed an 'anti-self-help' stance, although did not dismiss the fact of the groups' existence. Four individuals form the third respondent group, which represents an acceptance of the potential positive care-giving aspects of self-help. But their acceptance is tied to limitations also, expressly the need to incorporate physicians into the self-help treatment process. However, as has been stressed repeatedly throughout the previous chapters, this is a stance not compatible with the self-help groups included in this study. One sole respondent represented the fourth and final grouping, and was supportive as well as informed
about self-help groups, including those active in Vancouver, and participating in this study.

Several insights were gained from this exploration. Firstly, the 'guarding of professional turf' was recognized by respondents at both ends of the spectrum. This is an issue long recognized by the self-help community, but somewhat surprisingly the existence of internal controls upon medical professionals by other professionals (for example, concerning the participation of physicians in self-help) was frankly stated by several of the respondents. The theme of safe-guarding professional interests is one that weaves indirectly throughout much of what was said, but maintaining economic and social status, as well as professional control of the medical sphere was directly targeted by several physicians. Indeed, the possibility of not being able to maintain a certain standard of living posed a very real threat to those polled.

Secondly, the theme of limited familiarity with the notion of self-help was raised repeatedly. "It is not surprising that few physicians are shifting from the medical paradigm - these are paradigms they are not familiar with" (physician). And furthermore, "most doctors will not refer (to self-help), they don't even know about it." In fact, none of the physicians spoken to referred patients to self-help, but in fairness only five of the eight are practising physicians. This limited familiarity with self-help was also observed from comments other than those specifically addressing this question. Following a brief description of self-help, as defined here, several
physicians, including those purportedly familiar with this notion, repeatedly confused self-help with either (i) any group of individuals working with a medical professional to sort out problems or difficulties, such as in an encounter group or discussion group for patients undergoing, for example, kidney dialysis; or (ii) the view that one can be one's own doctor sometimes, and the limits of when it is and is not necessary to see your physician. Perhaps the influx of 'self-help' books on the 'pop-psych' and 'pop-med' market tout a greater influence than self-help as an alternative to the traditional medical paradigm, possibly since many of them are firmly entrenched in the latter.

From another aspect, most acknowledged that self-help is seen as being very confrontational not only to physicians but to the medical system in general, and cited this situation as a major reason for their non-interest in self-help. Whether or not greater professional interest would be spawned by the introduction of less confrontational approaches by self-help groups was not answered. "The confrontational model is of no use, except for getting attention." Still, the interviews point out that in many cases, perhaps even that has not been accomplished.

Among those receptive to self-help, the emergence of professional help as a backup to self-help, and vice versa, was a constant theme. Furthermore, those already receptive to self-help see an increasing acceptance of it by a more general audience of professionals, in accord with changes within a larger
sphere: changes in health care in terms of recognition of psycho-social factors in mental illness. "Given the social shift (in medicine) and more discussions on power (therein) they are more receptive. Now doctors are not getting bashed, but the whole social order" (physician). Still, however, in spite of some increasing support of many of the principles of self-help, ("Where people feel victimized, any increase in power has to be good for them - useful helpers must prescribe to this model."), self-help groups are still viewed by professionals as lacking in accountability. And therefore, taking all into consideration, self-help groups have not, by any means, rallied the support of the professional medical community.

Cooperation and a more outward reaching self-help model were discussed by all physicians, who were at least marginally supportive of self-help. In the words of one medical professional: "Let's face it, they do not have the clout to change the system." Another commented that "as long as there is a hierarchical model (of health care delivery) professionals won't support self-help groups." These views are, of course, very familiar to self-help groups, and this is partially the reason they do, in fact, shy away from professional involvement, that is, so they are not pulled into the mainstream. All of the physicians believed otherwise. "If you can't abolish the system, you must cooperate".

Cooperation, in addition to direct involvement in self-help, was suggested in several ways, most notably through conferences or coalitions. But whatever positive comments
were made on the issue of self-help, it was clear that none of the more or less 'pro-self-help' health care professionals would overtly support self-help without some type of direct involvement. In other words, an approval of self-help could occur only with the qualification of doctors playing a watchdog role in a self-help mode of health care.

Both physicians and the self-help group officers interviewed repeatedly cited the need for advocacy by self-help groups. However, this has occurred only very minimally in Vancouver. This may not be an easily attainable goal, however, since the inherent difficulties in finding and maintaining a professional audience have been documented, most recently by New York based self-help groups and published in the self-help forum Phoenix Rising (Frank, 1985).

The rivalry between lay people and professionals was termed as "conflict and politicking", and it was stressed that this rivalry was as strong coming from either the more traditionally rooted 'curative' physician or the preventative practitioner. As expressed during the course of these interviews, this conflict is not a conspiratorial one in nature, but a conflict firmly entrenched in professional mores and values. This does not represent an objective view, but it was observed (with a similar level of subjectivity) that the non-conspiratorial view does represent the situation among those polled. This supports the position presented by the author.

It is apparent that the medical community does act as a barrier to self-help, albeit elusively. One cannot, however,
provide evidence whether an indirect, or unintentional barrier exists (perhaps due to limited information and an already deeply rooted professional orientation) or whether the interviews represent an intentional refutation of self-help. Most probably, both direct and indirect oppositional forces are in motion. If clients are not channelled into the self-help stream, and some of the traditional physician-dominated trends of mental health treatment are not decreased (as seen by self-help advocates) then the efficient functioning of self-help on a larger scale is impaired.

In summary, no overt formal or organized barriers posed by the medical community may be documented. But conversely, there exists almost no contact, action or visible support for or with the self-help movement. The relationships are, to say the least, tenuous.

PUBLIC POLICY AND SELF-HELP FUNDING

Public policy and its effects upon operationalizing the self-help concept may be best demonstrated through the allocation of public funds to active self-help groups in the Vancouver area. Again, a somewhat tenuous relationship emerges.

An investigation of the funding sources of those self-help groups included here, reveals that all nonresidential services (e.g. drop-in centres) are funded by the Ministry of Human Resources, while similarly, all residential facilities receive funding from the Ministry of Health. Several groups
supplement these funds through the operation of a thrift shop (2), other fundraising activities (2) or limited corporate grants (3). Thus, at a superficial level, it may seem that public (provincial) policy is fully prepared to encourage and support self-help as an auxiliary to the existing, mainstream service provision system. However, an examination of the constraints and limitations posed by such a funding system may in fact, uncover trends that are only partially beneficial to the self-help movement, and possibly even hinder it.

A close look at funding criteria sheds much light on the actual purpose of funding groups such as these. Working under the auspices of the Community Contract Services Program of the Ministry of Human Resources, self-help groups, in effect, are simply sharing the burden of MHR prerogatives. The purpose of the Community Contract Services Program, under the statutory authority of Section 5 of the G.A.I.N. act, is stipulated as follows:

The purpose of the Community Contract Services Program is to make provisions for the purchase of services by the Ministry from non-profit societies in a community. These are to be obtained on behalf of persons who require or may require Ministry services. Those which might be purchased include those which are structured and organized to assist in improvement or social functioning and crisis management through the provision of information, guidance, positive experiences and social support. These must be supportive of or complementary to statutory services of the Ministry without duplicating existing programmes or infringing upon the areas of primary concern of other Ministries. (Community Contract Services Program, 1979, p. 1.412)
Furthermore, the criteria for receiving funds from the ministry include services which:

a) are supportive to Ministry services;
b) do not include services which the Ministry provides directly;
c) may include core costs relating directly to the purchased services;
d) are clearly specified by nature and duration;
e) are the subject of a written contract;
f) can be monitored as to performance of the purchased services;
g) are delivered on behalf of present or potential Ministry clients;
h) exclude capital expenditures;
i) are supportable subject to availability of Government funds.

(Community Contract Services Program, 1979, p. 1.412)

Thus even though the self-help groups funded by the MHR are thereby enabled to exist on a (generally) year to year basis through the Community Contract Services Program, they are, in effect, only licensed to fulfill the specific mandates of this provincial ministry. What transpires is the direct purchase, or contracting out of these services, to non-profit organizations throughout the province. As one group coordinator expressed, "We must take care of their (MHR) clients." In this specific case, the proportion of ministry clients under their wing is directly compensated with proportionate payments to this group. Other groups have differing exchanges which are contracted individually.

The self-help groups, then, have the potential of becoming a mere appendage of the public service provision system. However, it is a very beneficial situation for the public purse, since it enables a cost-efficient alternative,
which includes the utilization of many volunteers to accomplish the ministry's mandate. In return, the "self-help function is tolerated" (self-help groups coordinator).

Where residential services are concerned, however, groups may 'opt in' to the Long Term Care Division of the Ministry of Health. The group is then funded on a full or partial per diem rate based on the actual occupancy rate at a given time. Funds for other purposes (other than for uses directly related to lodging) must be obtained from other sources.

The contracting out of services, or rather the restrictions related to government funding in general, has been demonstrated to incur two limitations to the effective functioning of self-help groups: the weakening of supports and decreased control over range and type of support and activities offered, and secondly, possible cooptation.

The advocacy group TAG, to which most of the self-help groups included here belong, identified in a news release (1982) the impending collapse of social supports and housing alternatives to ex-mental patients. Indeed, all groups surveyed cited the need for increased numbers and improved quality of facilities, increased levels of activities and more paid staff. It was pointed out, again and again, that only a small number of those needing aid could be served, especially with respect to independent and semi-independent housing for ex-mental patients. The overwhelming response demonstrated that the limitations posed by budgetary restrictions were severe.
These restrictions, in turn, limited the groups' existence to the performance of the contracted service(s), but little else. Time spent on patient advocacy, patient rights, and the self-help movement is minimized, if obtainable at all. The art of 'grantsmanship' is highlighted, while other, potentially 'political' activities are curbed by sheer lack of manpower and other necessary resources. This is exemplified in the MPA, one of the cornerstones of the mental patients' movement which in the 1970's, started on a private donation of one hundred dollars, and served as a vital link to the movement through newsletters, lobbying and advocacy. Now, only 19 of the 39 respondents surveyed held any knowledge of the self-help movement, while only 9 of these 39 clients had ever been involved in such activities themselves. Having been informed about the movement, either in the past or as a result of this questionnaire, 32 of the 39 clients expressed a direct wish to now become involved, or at least to become more directly associated with the self-help or mental patients' movement.

This may suggest that self-help groups have been coopted. However, only two groups admitted that actual "cooptation may have occurred to some extent." "We realize that you have to compromise. Whoever is holding the purse strings has the say" (self-help group coordinator). Often it is not cooptation, but that they are "caught up in our own survival. We are not as outward looking" (coordinator). Still other groups realize that "because we are civil servants, there are things we can't do", but still do engage in political or controversial
activities in their own time.

Even though the original intent of the self-help movement has been stifled, and modified and that many of the more esoteric aspects of the mutual support movement, such as activism within the mental health field (lobbying, conferences, newsletters) have been curtailed, the reader must also be made aware that other issues not related to funding may be partially responsible for these changes in direction. (See Chapter Five)

There is also the possibility that the self-help groups serve another function, that of maintaining the credibility of existing traditional services and approaches to which they are directly opposed. Because of this, in some cases, concerns by groups over continued funding are somewhat minimized since they feel that they may be serving an important function from the perspective of funding bodies:

We are too important to the government. It's still cheaper than $360 a day at Riverview. We are too cost efficient. We are a last ditch stop for people who are too difficult - you know - the rebels. We make the system credible, we keep the people off the streets. (Group coordinator)

We keep it credible. In a system where there is a need for the MPA, we demonstrate the need for institutions like Riverview. (MPA coordinator)

Therefore, on one level, the self-help groups function only to carry out the services which form the mandate of the Ministry of Human Resources, through the process of contracting out. By their own admission, their activities have
been limited in both scope and range to those aimed at direct service provision. Both the scarcity of funds and the directives of the ministry which must be followed to secure funding in future years has facilitated a narrower approach than perhaps is welcome. But a tradeoff has been achieved. In exchange for providing necessary services for ministry clients, the self-help groups function in some capacity, and hope to use their initiative and resources to start expanding their own objectives.

There has been a certain amount of coopting going on. It's inevitable at certain stages, and I think we are endeavouring to turn around now. More internal accountability, not looking at what these funding bodies are saying (Group coordinator)

Public policy in terms of funding has facilitated the ongoing functioning of self-help groups in Vancouver. But it also plays the role of hindering the carrying out of their full mandate. The service provision aspect of self-help is carried out with full support of governmental structures, but at the present time, the broader, and perhaps more important aspects of the self-help movement are being overlooked. The major question, that is, how well they are functioning in spite of these external limitations, shall be examined in the following chapter.

SELF-HELP IN THE COMMUNITY

On the other hand, at a local, community level, public policy more clearly emerges as a reinforcement to self-
help groups, especially where residential facilities are concerned. This seems to be due to a tacit acceptance of such facilities, as is indicated in the zoning guidelines for the City of Vancouver which approve them. There is also a very tangible concern in Vancouver (unlike other cities) to disperse facilities and prevent the emergence of ghettos for the service dependent.

Several stipulations are in effect with respect to locating self-help (and other special needs) facilities. 'Drop-ins' or non-residential facilities are for the most part excluded, since they are usually situated in store-front or similar properties zoned for commercial use. On the other hand, residential facilities are more closely scrutinized, especially if a formerly single family dwelling is to be converted for this purpose. Theoretically, all facilities applying for a Development Permit must follow a rigorous procedure, whereby surrounding residents must be notified and allowed to present objections to the proposed facility.

In all cases, neighbouring residents who could be affected, as determined by the Director of Planning, shall be notified of Development Permit applications for Special Needs Residential Facilities and be given opportunities to express their views in writing before permits are granted or refused. (Extract from the Minutes of the Standing Committee on Planning and Development, October 18, 1979)

However, as stated above, the Director of Planning maintains the discretionary power to determine which cases could be 'affected' and remove this notification requirement. Further-
In cases where there is concern that a Special Needs Residential Facility may prove disruptive to a neighbourhood, development permits may be granted for limited periods of time, with the understanding that permits to continue use may be granted as long as operations prove compatible with neighbourhood life. (ibid.)

This clause also empowers the Director of Planning to grant a development permit even in cases where widespread objections have been demonstrated.

These guidelines have proven to be beneficial to self-help groups in Vancouver. Contrary to findings reported in earlier chapters based on research elsewhere, the Vancouver situation demonstrates that local policy need not be a hindrance to the conflict-free location of facilities for ex-mental patients or other individuals in residential communities. Again, city bylaws have been at least partially responsible for a mitigation of conflicts in communities, since Clause 4, sections (iii), (iv) and (v) of Policies and Procedures for Controlling the Development of Residential Facilities for the Handicapped, the Elderly and Others with Special Needs (1983) prohibits the clustering of facilities that have in other cities resulted in the ghettoization of the mentally ill, a state which seems to automatically instill fear and mistrust in residents who are aware of a proposed location of such a facility in their area. Consider, in contrast, the Toronto experience. While in most of the inner census tracts the distribution of community mental health facilities is relati-
vely dispersed, the more suburban areas remain almost untouched. Conversely, the Parkdale area is saturated with facilities. Indeed, this applies not only to facilities for ex-mental patients, but to special needs facilities of all types, including those for the handicapped and children's services. Joseph and Hall (1985) demonstrate, that in Toronto, psychiatric services have been shown to exhibit the highest rates of concentration over all other facility types. Assuming an equal facility per population distribution, the City of Toronto has double the number of facilities one might expect when compared to the outlying municipalities (York, Etobicoke and North York), which are significantly underrepresented in their numbers of special needs facilities.

A markedly inequitable distribution also exists within the City of Toronto, thereby further exacerbating this concentration. In particular, the minor planning districts of the Annex and Parkdale South are saturated. In these areas, "sectoral concentration" is especially evidenced, since there is an overrepresentation of facilities for ex-mental patients, including many 'unofficial' (unlicensed or non-recognized) boarding homes (Joseph and Hall, 1985).

It is no coincidence that the Parkdale riding is the locus of the Queen Street Mental Health Centre, Toronto's oldest and largest institution for the treatment of mental illness. This area is characterized by a cluster of licensed facilities, many more unlicensed facilities as well as rooming houses and flophouses. Queen Street houses, in one way or another, the
institution's ex-patients who are not welcome in many of Toronto's other areas. This is the mental patients': ghetto, which is still at the forefront of the Canadian controversy.

Joseph and Hall (1985), like Dear and Taylor (1982), stress that the oversaturation of some areas is not simply the result of an amassing of individual decisions. Rather, this situation is rooted in a series of interconnected conditions, including the existence of a large client population (such as from the Toronto Queen Street facility) coupled with a particular urban infrastructure (including appropriate convertable housing), municipal bylaws and planning policy, and the capabilities and motivations of area residents to form alliances in order to bar special needs facilities from their communities. With respect to this last consideration, opposition to facilities from area residents, Dear and Taylor (1982) strongly suggest (but do not confirm) that in Toronto, a greater proportion of facilities is located in areas of least resident opposition. The definition of such 'least opposition' areas is based on an array of socioenvironmental variables, which are used to predict typical 'accepting' or 'rejecting' neighbourhood profiles. This in turn suggests that in this particular case, areas prone to exhibit opposition have been excluded from acting as hosts to boarding homes and other facilities. In fact, the use of least-risk planning strategies and the practice of resolving locational conflicts in favour of the exclusionary attitudes of neighbourhood residents have been documented in Toronto (Dear and Taylor, 1982).
In Vancouver, however, much of the controversy associated with these issues has been bypassed. In spite of massive deinstitutionalization in this city as well, as cited in Chapter One, there is a marked absence of areas saturated with mental health facilities (Figure 2). These facilities, including mental health boarding homes and half-way houses (to be consistent with the Dear and Taylor, 1982; and Joseph and Hall, 1985, findings) are not clustered, but relatively dispersed, with the exception of slight concentrations in the Kitsilano and Mount Pleasant neighbourhoods. No single area can be defined as being overrepresented in terms of such facilities.

Again, this pattern is not a purely coincidental one. Whereas in Toronto, biased planning policies have historically been utilized to keep some suitable areas (that is, those close to amenities, with appropriate architectural properties) relatively facility free, Vancouver has adopted a 'fair share' policy. The application of the bylaws and guidelines discussed above has resulted in this dispersed and relatively conflict free situation.

Consider the case of the boarding homes, apartments and store-front facilities directly associated with the nine self-help groups included in this study. Although much debate over this issue may be witnessed in the local press over special needs residential facilities of many types, the residential facilities directly related to the groups included here have escaped this controversy, with the exception of one faci-
FIGURE 2

GEOGRAPHICAL DISTRIBUTION OF MENTAL HEALTH BOARDING HOMES IN VANCOUVER
lity. In a survey of the nine residential facilities (excluding new apartments) affiliated with the groups included here, three had no development permit on file (for reasons unknown by planning officials), and three other residences were granted development permits prior to 1975, when notification of surrounding residents became policy. One boarding home, granted a development permit prior to 1975 (October, 1973) received an additional permit in 1976, to add bedrooms to the boarding house without the notification requirement. This occurred, since it was assessed that this site had previously been cleared for this use. Two facilities were granted 'no notification' status, at the discretion of the Director of Planning. In fact, only one boarding home in question went through the notification procedures, and did encounter opposition. The objections cited in the residents' letters included: (i) that the proposed use would be detrimental to the stable residential character of the area; (ii) that property values in the area would decrease; (iii) fears for children and the large contingent of elderly people in the area; (iv) concern about the transient nature of the proposed home's residents; (v) increased traffic flows; and that (vi) the addition of a fire escape would not be in keeping with the character of surrounding homes.

This facility was, however, granted approval for a limited time period (one year, subject to review) and still operates today.

Perhaps the fact that a low level of opposition has
been witnessed specifically with respect to those facilities considered here has been the result of an absence of notification procedures to surrounding residents. Furthermore, the no-notification decisions directly reflect the fair share policy which strives to allot facilities to as many suitable areas as possible. Nevertheless, very few objections have been voiced against these facilities at any time, either to city hall or the groups themselves. This has more often than not been the case, since these facilities are 'non-visible' in the community. If residents are not alerted to their presence they often remain unnoticed. This supports previous research outlined in Chapters One and Two. Similarly, the drop-ins have received no complaints, with the exception of the MPA drop-in, a highly visible centre in a mixed use, although predominantly residential area. However, a decade ago the MPA reported constant pressure from residents in the vicinity of the MPA group residences, who voiced vehement opposition to these facilities. It was noted, that the dissatisfaction with these residences was based mainly on fears associated with ex-patients residing in their neighbourhoods (Phillips, et al., 1977).

Thus planning policy makers have attempted to exhibit accepting qualities to self-help through the location of their affiliated residential facilities, and largely because of this the community itself has not rejected them. While there does exist a noticeably, yet not markedly, higher proportion of facilities in Kitsilano and Mount Pleasant, it
must be noted that there are few areas encompassing all of the attributes contributing to optimal locations for residential facilities: they are centrally located, are near public transportation routes and therefore easily accessible, and contain many large, older houses which are easily adapted to group home use. Thus the concentrations in these areas, as long as they remain slight, cannot at present be described as 'oversaturated' or subject to 'dumping'.

SUMMARY

In summary, the professional community and public policy vis-à-vis state funding for self-help groups cannot be said to act as direct constraints for self-help groups, but are in general non-supportive and especially in the latter case, impose severe limitations to a full implementation of service related and politically oriented goals. By non-acknowledgement and certainly non-support of self-help from medical professionals, the movement loses credibility and bypasses many individuals who may receive some benefit from it, in place or in addition to professional support. And, by being restricted to direct service provision in lieu of broader aims (both by extent of funding and state funding guidelines) a true mandate is not fulfilled. Local zoning policy in Vancouver, however, does not share this limiting effect, and furthermore, has facilitated the appearance of minimal opposition for many self-help residential facilities by diluting or minimizing adverse public attention and reaction to these facilities.
This, however, may not be the case in cities other than Vancouver. In the next chapter, an evaluation of the efficacy of these groups, in light of these constraints, will be examined, followed by an outline of theoretical perspectives which may be a useful analytical tool for the investigation of this issue in the future.
CHAPTER FIVE
MENTAL HEALTH SELF-HELP:
IMAGE AND OUTCOME

Yet the image was just that: an image. They even called it that and never noticed what they'd said. The reality differed. (Philip Wylie, in Stanton, 1970, p.1)

Almost invariably, the transition from the image of self-help (the original conceptualization) to reality (the outcome) involves changes in both intent and direction. In the previous chapters, those factors which intervene in the process of operationalizing such a concept have been formulated and investigated. It is apparent, that the outcome is the product of a filtering process, through which the concept of self-help must pass in order to emerge as an operational mode of mental health care.

In this concluding chapter, these constraints (public policy, professionalism, and the community) are redefined as part of this complex filtering system. Because of the dominant effects of the professional and public policy filters in particular, self-help groups in Vancouver have altered their original plans, both philosophically and practically. And, as result, it can be shown that in many respects, they are not able to carry out their full mandates. The extent to which this has occurred shall be discussed below, with emphasis on four major considerations: philosophical changes in the direc-
tions of the self-help groups, their ties to the movement from which they stem, and those practical changes which had to be instituted as a result of the constraints they face in their ongoing activity. Most importantly, perhaps, the effectiveness of the mutual aid function, in spite of the formentioned adaptations, is evaluated. Finally, the theoretical implications are discussed, and both theoretical and practical recommendations for future work in this field are suggested.

ASSESSING SELF-HELP IN PRACTICE

Regardless of the difficulties and barriers facing emergent and operationalized self-help groups - control from outside funding sources, potential and actual conflicts within the professional community, and community opposition which may be reinforced through local zoning procedures - the Vancouver groups are fulfilling their mandate as agencies creating mutually supportive environments. But in many ways, they have had to compromise some of their initial ideals, and thus Philip Wylie's words ring true to some extent. But on the other hand, they continue to serve hundreds of Vancouver area residents.

The roots of any self-help organization, as defined here, are of a philosophical and political nature, but their objectives also include a variety of service provision, and clinical or pragmatic concerns. As stated in Chapter One, self-help can be seen as an alternative to conventional modes of care, challenging existing power structures between patients
and physicians, as well as providing services not typically provided by mainstream agencies. But underlying the group specific goals in the self-help movement lie broader, more radical goals which challenge the status quo. Therefore, the goals of self-help transcend the boundaries of mental health, and implicate the broader issue of equalizing power in the medical establishment and other segments of society.

Of the ten groups investigated in Vancouver, seven could state that the philosophical bases of their work encompassed (i) the value of mutual support as a vital component of maintaining mental health; (ii) the need to establish and work within a non-hierarchical structure, (iii) the need for decreasing reliance on professional care and (iv) the recognition of the social and cultural roots of mental illness and emotional distress. The remaining groups, however, seemed to have difficulty in pinpointing a central philosophy but cited both their educational and mutual support foci. Without exception, all groups stressed a powersharing structure encompassing reciprocity, involvement and complete client control over the mutual aid environment. However, one group coordinator indicated that in spite of this philosophy, the participants of their elected board of directors were directly involved in mainstream social service provision, "which doesn't make for a great board (of directors)."

Similarly, the group control by mental health or general health professionals was shunned by all groups. That "people can be the best experts" is a strictly adhered to
adage, but judiciously selected professionals were occasion­
ally consulted by three groups. In particular, social workers
who have the power to place individuals in programs or housing
situations were consulted. Other groups emphatically avoided
the incorporation of any professional whatsoever, although
generally, the groups were in agreement that the traditional
stance and viewpoint was not beneficial in these, self-help,
situations.

Thus, seven of the ten groups recognized a firm
self-help philosophy as the central element in their organiz-
ation. However, the officers of all groups questioned admitted
a softening of this stance, a loss of recognition of these aims,
and an increasing emphasis on pragmatic considerations in lieu
of the continuation of the original philosophically rooted aims.
This was most evident in the two groups exclusively for ex-
mental patients; both groups originally viewed as prototypes
of self-help groups in the field of mental health, and both
espousing rather radical political and medical views. In
these instances, their anti-psychiatric stance has also
weakened significantly, and in one case was viewed merely as a
past, but not present, concern.

This trend toward moderation and the resultant lack
of a philosophical basis among members is well evidenced in
the responses of the questionnaire distributed to the members
of the Mental Patients' Association (MPA). (See Chapter Three,
also Appendix IV.) Among the attributes of the MPA, their drop-
in was deemed most important. Also, attributes including
mutual aid, friends, workshops and employment were the most frequently cited (Table IV). Adherence to a MPA philosophy was a reason volunteered by only one of the 39 respondents. When respondents were given an opportunity to volunteer attributes they felt were most important to the functioning of the MPA, rather than respond to a checklist, only ten reasons were suggested in all. Four respondents mentioned caring treatment, while the need to continue functioning as an organized entity was mentioned once. However, two respondents did cite the patient advocacy role of the MPA while an additional three members cited the importance of power sharing or participatory democracy. It is interesting to note, that there is no variation in the distribution of responses when broken down by the duration of respondent membership in the association. This may have been expected taking into account the markedly radical activities of the MPA several years ago.

Even more apparent is the lack of any formalized ties with the self-help movement, or even between self-help groups, in spite of the existence of a vocal and active movement, under whose auspices conferences are organized, information is distributed and much political lobbying is accomplished. (This is more evident in the United States than in Canada.) Three groups described their ties to any broader movement as being "limited", two others recognized their involvement as being "implicit" (i.e. they saw themselves as being a part of the movement because of their existence as a self-help groups, and because of their information dissemination and mutual
TABLE IV
USER-ASSESSED ATTRIBUTES OF THE MENTAL PATIENTS' ASSOCIATION

<table>
<thead>
<tr>
<th>Rank</th>
<th>Attribute</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Friends</td>
<td>17</td>
<td>43.5%</td>
</tr>
<tr>
<td>2</td>
<td>Meetings and workshops</td>
<td>8</td>
<td>20.5%</td>
</tr>
<tr>
<td>3</td>
<td>Employment within the MPA</td>
<td>6</td>
<td>15.3%</td>
</tr>
<tr>
<td>4</td>
<td>Support/Help</td>
<td>5</td>
<td>12.8%</td>
</tr>
<tr>
<td>5</td>
<td>Aiding other ex-patients</td>
<td>2</td>
<td>5.1%</td>
</tr>
<tr>
<td>5</td>
<td>Finding employment</td>
<td>2</td>
<td>5.1%</td>
</tr>
<tr>
<td>6</td>
<td>Belief in the MPA philosophy</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>41</td>
<td>100%</td>
</tr>
</tbody>
</table>

* While some respondents mentioned more than one category, others did not respond to this question.
aid functions); while the remaining five groups stated that they had "no ties" with any broader movement. Whatever the extent of their involvement, no clearly defined role could be articulated, however, by any of the groups and thus the roles of even those groups with limited involvement could only be described as being ambiguous.

This same ambiguity is demonstrated by the response of the members of the MPA. While this organization originated within the self-help movement, and particularly the mental patients' movement, only approximately one half of the 39 members surveyed were familiar with the movement (19), while the other half were not (20). Although most of the respondents had been members over one year, there was an indication of a propensity of longer term members to be more familiar with the broader movement. This is hardly a surprising revelation, but what is more interesting is the rather larger proportion of members interviewed who have been with the MPA for one year or longer, and who were not at all familiar with any aspect of a broader self-help or mental patients' movement.

In most cases, the officers of the self-help groups could articulate quite specifically the softening of their group philosophies. But again, they could not define exactly what this softening entailed. In all cases these shifts were attributed to funding and budgetary restrictions. Clearly, funds are simply not available for activities, such as trips to conferences, that lie beyond the range of service provision (operating expenses, residential and emergency service costs,
etc.):

The MPA still has a 'tainted' reputation of sixties radicalism, anti-establishmentarianism. Our ties with the movement are loose. How can you inform people, attend conferences, when no money is available? We are not in a monetary position to do so. (MPA group coordinator)

Also, there does exist a recognition among the groups and their coordinators that they are in a position where they could be assured of not only continued funding, but also of a tolerance of their often anti-psychiatric activities only if their activities are limited and not publicized to any extent.

Our salaries, our budget are lower than anybody else in the world... because they accomodate our philosophy. (Group coordinator)

Back to the issue of being coopted. We are totally funded by the government, we do not generate our own revenue. (Group coordinator)

Thus assurances of continued funding tend to override any suggestions of activities other than those which are directly service related.

We have changed direction. This, I think, happens to any organization that looks toward outside funding, which is almost inevitable. (Group coordinator)

But when constraints have had effects on the fore-mentioned philosophical changes beyond the availability of funds for 'peripheral' activities, specifically, this entails changes in the nature of the organization itself. All of the associations surveyed, are, at best, struggling financially, therefore dealing with overworked staff, and cutting corners on programs.
As a result, these organizations become increasingly inward-looking, and their concerns gravitate almost completely toward the most essential needs; the more esoteric and idealistic needs fall by the side. "Because we are now caught up in our own survival, we cannot be as outward looking" (group coordinator).

A decreased ability, as seen by the groups themselves, to deal with the entire spectrum of members' problems and service needs also compels them to rely more and more on outside established institutions. This too, occurs in the event that funding is limited to specific programs, or restricts employee numbers. More typically, membership rates may have increased significantly with little or no corresponding increase in funding. Furthermore, by contract with funding bodies (usually the Ministry of Human Resources), self-help groups are compelled to cooperate with existing institutions operating through these same or other funding bodies. Ultimately, the stance toward traditional services is now relatively open.

As stated by one group coordinator:

*We are not so much anti-psychiatry now. The MPA has softened to try to encourage people to use 'the establishment' when it works for them.*

or,

*We are not outrageously impressed by the psychiatric system, but we feel that there are so many alternatives (to the system) available. But, we don't want to close any doors.*

In two cases, very direct warnings that funding might not be continued if specific activities were not stopped
led to a similar, but rather abrupt moderation of the groups' positions.

In terms of funding you've got your head on a block. You can be advocates up to a point. So we try to shy away from it. Everybody around here is political - there is no doubt about it.

(Group coordinator)

Where any political activity was demonstrated, the organizers were very clear in pointing out that while they were, perhaps, very active, they participated as individuals but definitely not as an organization. Members and volunteers were particularly encouraged to do so, since, in the words of one group coordinator, "you can't fire a volunteer."

Fiscal and structural changes within the health care system as a whole have had dramatic changes on self-help groups, on their philosophical viewpoints and their motivation to participate on a wider scale. Most notably, a decrease in the duration of hospital stays (with an increase in the recidivism rate), which is in turn facilitated by the widespread use of psychotropic drugs, has created the emergence of a new breed of ex-patients, who are significantly more dependent than their more outspoken counterparts of a decade ago. Ex-patient reliance on the welfare system, the health care system, and now especially, the penal system is noticeably greater as a result. These factors, coupled by the lack of support services for discharged patients results in a situation where "people are being discharged from Riverview sicker and faster than ever before ... Many former patients are simply on their own, with no place to go when they are flipping out" (In a Nutshell,
Thus, just as the groups have more immediate needs to tend to than philosophical and political battles, many of the patients now being released are similarly and justifiably interested in survival, recuperation and normalization, and lacking the resources and motivation for more esoteric, ideological concerns.

Thus the continuation of a hard line philosophical perspective and also ties with the self-help movement have been altered dramatically from the activities of the small handful of self-help groups for ex-mental patients at the beginning of the 1970's. This has mostly been due to funding constraints at various levels, which also have contributed directly or indirectly to changes in the structure and activities of the organizations themselves.

A third effect diluting the original conceptualization to produce a working self-help model is the requisite to implement changes in the more pragmatic aspects of the day to day operations of these groups, as defined by the funding bodies. In general, the disruption here is minimal, and even then, has usually been circumvented. These practical constraints are mainly of a bureaucratic nature, including the insistence on maintaining patient files and releasing pertinent patient information to ministry officials. In most cases these regulations are either ignored, negotiated, or more often, "there is a certain amount of fabrication going on" (group coordinator).

Fourthly, perhaps the most important factor in assessing the changes brought about through the operationaliz-
ation of the self-help mode is the effectiveness of the mutual aid function of these groups, in spite of the accommodations that may have been made philosophically and politically.

Perhaps the most basic indicator of effectiveness is a user evoked rating. The results of the Mental Patients' Association questionnaire indicate a very favourable response (Table V). All respondents, when asked how they would rate the effectiveness of the MPA on a five point scale, ranging from "not at all helpful" to "extremely helpful" rated it as either "extremely helpful" (51.3%), "very helpful" (25.6%) or "somewhat helpful" (23.1%). No respondent indicated that the MPA was "not very helpful" or "not at all helpful". While it is not unreasonable to argue that since the questionnaire was distributed at the MPA facilities, only individuals who found the MPA helpful would be likely to participate in the survey, it seems that this is not the whole story. Since there are factors other than the mutual support role of the MPA which would attract them (housing and employment services, for example), and noticing that even some long term members reported only moderate levels of helpfulness, it seems that the sample would not be skewed to omit those members of the MPA to whom the MPA and its programs are ineffective. Secondly, it is unlikely that negative inferences to the MPA were omitted for fear of retribution or ostracization, since all questionnaires were completed anonymously. However, since it is unlikely that those answering "not at all helpful" would be at the MPA at all, one may conclude that the findings are repre-
### TABLE V

**PERCEIVED EFFECTIVENESS OF THE MENTAL PATIENTS' ASSOCIATION**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Duration of membership in the MPA</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>many years</td>
<td>1-3 years</td>
<td>6-12 months</td>
<td>2-6 months</td>
<td>&lt; 2 months</td>
<td></td>
</tr>
<tr>
<td>Extremely helpful</td>
<td></td>
<td>3</td>
<td>11</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>(51.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very helpful</td>
<td></td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>(23.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat helpful</td>
<td></td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>(23.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not very helpful</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Not helpful</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>6</td>
<td>18</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>38*</td>
</tr>
<tr>
<td>(15.3%)</td>
<td></td>
<td>(46.2%)</td>
<td>(7.7%)</td>
<td>(12.8%)</td>
<td>(15.3%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* A response was not elicited from one respondent, thereby reducing the total number of respondents to 38.
sentative of the active MPA members and residents of MPA residences and apartments.

The most important attributes of the MPA, as indicated by the questionnaire responses, are illustrated in Table VI. The top ranking responses (respondents were asked to check more than one, if applicable) were to meet friends (56.4%), gain independence (41.0%) and talk to people about shared experiences (28.5%). This is not surprising, since all of these reasons coincide with the self-help concept itself. What is somewhat surprising, however, is that the next highest ranking attribute of the MPA is that it is "somewhere to go", suggesting the great meaning attached to the knowledge that a nonhostile environment exists where they can simply go for support. Almost all of the group coordinators mentioned at some point in the interview the importance of having such a place to get away, to drop in to talk to others in similar situations, or to simply drop out. As one coordinator quite simply expressed, "there are a lot of quite isolated people out there", victims of social isolation and stigmatization.

Another indication of the effectiveness of the mutual support function of the MPA lie in the volunteered responses with respect to the best attributes of the MPA (Table VII). Again, the most frequently cited attributes dealt with support and the non-dominated structure: the people (25.6%), member input (23.1%), support (20.5%) and the sharing of experiences (15.3%). Conversely, when queried about the aspects of the MPA that respondents did not like,
### Table VI

**Significant Attributes of the Mental Patients' Association, as Ranked by Members**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Attribute</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Place to meet friends</td>
<td>22 (54.4%)</td>
</tr>
<tr>
<td>2</td>
<td>Place to gain independence</td>
<td>16 (41.0%)</td>
</tr>
<tr>
<td>3</td>
<td>Place to talk about experiences</td>
<td>15 (38.5%)</td>
</tr>
<tr>
<td>4</td>
<td>Somewhere to go</td>
<td>14 (35.9%)</td>
</tr>
<tr>
<td>5</td>
<td>Helpful in finding employment</td>
<td>10 (25.6%)</td>
</tr>
<tr>
<td>6</td>
<td>Helpful in finding housing</td>
<td>7 (17.9%)</td>
</tr>
</tbody>
</table>
### TABLE VII

**POSITIVE ATTRIBUTES OF THE MENTAL PATIENTS' ASSOCIATION, AS RANKED BY MEMBERS**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Attribute</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The people</td>
<td>10 (25.6%)</td>
</tr>
<tr>
<td>2</td>
<td>Member input/democracy</td>
<td>9 (23.1%)</td>
</tr>
<tr>
<td>3</td>
<td>Support</td>
<td>8 (20.5%)</td>
</tr>
<tr>
<td>4</td>
<td>Shared experiences</td>
<td>6 (15.3%)</td>
</tr>
<tr>
<td>5</td>
<td>Jobs and activities</td>
<td>4 (11.3%)</td>
</tr>
<tr>
<td>6</td>
<td>Belongs to ex-patients</td>
<td>3 (7.7%)</td>
</tr>
<tr>
<td>6</td>
<td>No stigmatization</td>
<td>3 (7.7%)</td>
</tr>
<tr>
<td>7</td>
<td>Music</td>
<td>2 (5.1%)</td>
</tr>
<tr>
<td>7</td>
<td>Free coffee</td>
<td>2 (5.1%)</td>
</tr>
<tr>
<td>7</td>
<td>Independence</td>
<td>2 (5.1%)</td>
</tr>
<tr>
<td>8</td>
<td>Patient advocacy</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>8</td>
<td>Housing</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>8</td>
<td>Long hours of drop-in</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>8</td>
<td>Suppers</td>
<td>1 (2.5%)</td>
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the tedium of the democratic process was mentioned by 20.5% of respondents. In fact, this is a sentiment shared by MPA members and officers alike. Since this self-help group strives to fulfill its power sharing mandate and maintain the non-hierarchical organizational structure on which it was founded, participants must become involved in a seemingly endless string of meetings. The proceedings of the meetings adhere to strict rules of order to discuss major policy decisions or the maintenance of the coffeepot, either at MPA general meetings or weekly discussions. In addition to the perceived although necessary burden of this democratic process, eleven other negative attributes were mentioned, although with considerably less frequency, and were concerned more with the pragmatic (although not less real) problems within the MPA, such as cleanliness, noise and activities (Table VIII).

The officers of all agencies were also positive with respect to the mutual aid function. In all cases, the groups were fulfilling their mandate to help individuals increase their levels of independence and ability to make decisions, and disseminate information. This is especially so in the residential settings, where informal aid is available around the clock, and more formally during organized sessions.

Of the 39 MPA members surveyed, 25 (64.1%) had never resided in MPA housing, and 6 (15.4%) had resided in MPA housing at one time, but not currently. All six cited increased independence and the resultant ability to live alone as the
<table>
<thead>
<tr>
<th>Rank</th>
<th>Negative Attributes</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tedium of the democratic process</td>
<td>8 (20.5%)</td>
</tr>
<tr>
<td>2</td>
<td>Shabby appearance of drop-in</td>
<td>6 (15.4%)</td>
</tr>
<tr>
<td>3</td>
<td>Lack of empathy, at times</td>
<td>5 (12.8%)</td>
</tr>
<tr>
<td>4</td>
<td>Internal politics</td>
<td>4 (10.3%)</td>
</tr>
<tr>
<td>5</td>
<td>The members</td>
<td>3 (7.7%)</td>
</tr>
<tr>
<td>6</td>
<td>Lice</td>
<td>3 (7.7%)</td>
</tr>
<tr>
<td>6</td>
<td>Negative attitudes</td>
<td>3 (7.7%)</td>
</tr>
<tr>
<td>6</td>
<td>Smoking</td>
<td>2 (5.1%)</td>
</tr>
<tr>
<td>7</td>
<td>Loud music</td>
<td>2 (5.1%)</td>
</tr>
<tr>
<td>7</td>
<td>Too few ex-patient employees</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>7</td>
<td>Insufficient activities</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>7</td>
<td>Sexual harassment</td>
<td>1 (2.5%)</td>
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</table>
reason for terminating their tenure. The remaining 8 (20.5%) currently reside in an MPA residence; four in the apartment residences (greater independence) and four in the boarding residences (less independence). Again, when asked why they chose MPA housing, the mutual support theme surfaced again, and was mentioned by 5 of the 8 residents. Other reasons included reasonable rent, the fact that it was an appropriate and available place to go following hospitalization, and the semi-structured atmosphere of these residences.

Yet another indicator of the effectiveness of self-help is the current recidivism rate among members, but this is applicable, of course, only to those groups whose membership is comprised mainly of previously hospitalized patients. Unfortunately, no current information has been compiled to illustrate any upward or downward shift in recidivism due to the mutual support function of self-help. However, the subjective responses to this question, elicited from MPA members, are positive: 59% of all respondents stated that membership in the MPA did, in fact, act as a deterrent to hospitalization; 28% stated that it did not, and this question was not applicable to the remaining 13%. Once again, the overriding reason cited was the support function (mentioned by all of the respondents answering positively). Other reasons included the belief that the MPA helped them achieve an increased sense of self worth, increased independence, the realization that they are not insane, and simply having a place where they belong.

There does exist objective data that also lends
support to the subjective responses of the MPA members, although unfortunately it is already outdated by a full decade. This information was collected by members of the MPA during a two year period between January, 1974 and December, 1975. The statistics indicate a recidivism rate of about 10% of a total sample size of 129 residents of MPA boarding homes, while the recidivism rate generally at the time was thought to be as high as 60%. In fact, within this time frame, 43% returned to the community completely, while 74% showed significant improvement (Phillips, et al., 1977). This dramatically reduced rate was directly attributed to the supportive nature of their programs and power equalizing structure. And, indeed, at that time a non-hierarchical residential arrangement for ex-mental patients was (and still is) a unique phenomenon.

The self-help groups do provide understanding and nonstressful settings. MPA members questioned about what was so different about their group mentioned most frequently the fact that mental patients were not stigmatized there, that they were surrounded by individuals of similar backgrounds and experiences, and that the group provides a therapeutic setting and also a non-discriminatory one.

In general, then, the data strongly suggest that there does exist a strong mutual aid function within self-help groups. The strength of this conviction noted in the MPA questionnaire responses demonstrates this clearly, and includes statements such as:

MPA is excellent and should grow.
Psychiatrists are not good psychology, the MPA is.

The MPA is a good alternative to (the) mental health system, the MPA will run. [sic]:

The best quality I've found (in the MPA), and this is a rare one – is honesty.

What is special in the MPA is the strong unity of people, but it is not shown all the time. And it doesn't need to be.

And from a coordinator at a similar drop-in:

Give them a chance to become more of a person, at their own rate ... they don't have to participate in programs. For example, they can come to the drop-in for months without even playing a game of cards. But eventually they will choose to participate – if it does take that long.

And furthermore,

We make a community where it doesn't exist geographically.

Yet at the same time some very serious shortcomings are noted by coordinators and members alike. Because of the greater level of dependency in patients during the last decade (due in part to the use of psychotropic drugs, as mentioned above), there exist higher numbers of ex-patients for whom the mutual aid aspect of self-help, as it can be practised with current funding levels, is insufficient. And for some, it seems completely inappropriate.

ECT (electroconvulsive therapy) and drugs make people incredibly malleable, and looking toward a hierarchical system ... therefore (these) people are turned off from (the) MPA,
especially at the beginning.
(MPA coordinator)

This problem was also frequently mentioned in the MPA questionnaires. Apart from brief mentions of inactivity and stagnation, some respondents wrote more extensively:

Drugs control the illness - they don't overcome it. People are not getting well. For some, MPA is an excuse to remain sick or non-functional. I'm not sure what can change the stagnation of people here - but I see there are no real goals. People help each other in the daily running of this organization but if you were here six years ago you'd see the people sitting, smoking and not as ill as most are today. Self-help groups need to create direction (for them) and aim for improvement, not just aim in running a good ship.

Even more pronounced is the expressed exasperation, that if the mutual aid function is indeed, functioning, that there is simply not enough of it to go around.

The reality... is that the chronically mentally ill are today more likely to be out on the streets without services to give them direction and support. There are extensive community support services in Vancouver, they are even considered a model for other cities, but there are not nearly enough services to meet the demand. MPA's residence program, for example, is equipped to accommodate 46 people. It is a worthwhile and needed service, but it is only a drop in the bucket compared to the range of services required if the move to deinstitutionalize mental patients is ever to become a success... Along with pressure on the politicians, the public has to be made aware that many chronically mentally ill people are simply on the streets hungry, cold and crazy. Some might argue that this is an improvement over having 4,000 patients live at Riverview, but it certainly cannot be the
desired result of the plan to get mental patients out of the hospital and back to their communities. (In a Nutshell, 8(1), p. 4)

What have been the effects, then, of this filtering process, passing the concept of self-help through a set of constraints to achieve a desired outcome? In this case, the result, to some extent is that the outcome is not as desired. And although the direction has changed, the intent to pursue this outcome does remain a plan to be realized by most groups in at least a limited capacity. In Vancouver one can witness a significant lack of philosophical and political orientations which are, at least conceptually, inherent to self-help. At the same time, the questionnaire data point out that individually, "there is a high political awareness, but sometimes people don't know how to pursue that" (group coordinator). The fact that some awareness exists is evidenced at the end of the questionnaire, which contains comments almost exclusively relating to patient rights, community alternatives and reforms in psychiatric treatment. Less importantly, some practical changes have been instigated as well, but in most cases adaptations and compromises have been made so that the integrity of the group or efficient day to day functioning is not compromised. Lastly, while the mutual aid function is seen to be operating very successfully, it is noted as being insufficient for a certain patient population which is constantly growing in number.

It is clear, then, that self-help groups are still
able to function and aid hundreds of Vancouver area residents, in spite of the constraints posed by the community, the professional community and funding bodies. But nevertheless they do represent a somewhat diluted version of their original objectives.

ASSESSING SELF-HELP IN THEORY

To represent the operationalization of self-help within a cohesive theoretical framework is not an easy task. By examining this phenomenon in a holistic manner, as was attempted here, many theoretical formulations seem to fit only partially. However, two approaches may be more appropriate, and it is further suggested that they be viewed as complementary rather than incompatible frameworks.

Firstly, the Marxist view of social relations encompasses the question of conflict and struggle towards conflict resolution within the capitalist system. Within this framework, the self-help mode of care giving is seen as a confrontation with the dominant classes over the control of health care. By adopting a Marxist framework one attempts to relate societal events and mechanisms to the underlying economic structure, that is, the capitalist mode of production.

Central to Marxism is the notion of the formation of social class and class conflict. Marx envisaged a dichotomous class model of society determined by the degree of control over the means of production and those forms of exploitations which
become an integral component of a particular productive mode. In capitalism, class conflict is said to arise as a result of those contradictions between the forces and relations of production which are inherent in capitalism. In this manner, a rising consciousness on behalf of the proletariat occurs as a direct result of the exploitative forces and inequities incurred by them (Bassett and Short, 1980). Within the capitalist mode of production, the divergent interests of capital and wage labour are clear. According to Giddens (1976), they differ not only in terms of economic gains via production, but also in the interests promoted by each side with respect to the socialization of housing, property, education, etc., and also the locus of control in the productive sphere. Therefore, latent or manifest conflict between classes is inevitable in capitalist society.

Likewise, the health care system, viewed as one segment of capitalist society, nevertheless mirroring the complexities and processes inherent to this society as a whole, may also be described as being controlled or dominated by certain classes. According to Navarro (1975, 1977), these are essentially the same classes that exercise control over other areas of production, consumption and legitimization. In this sense, certain class interests which seek to preserve the current status of the health care system, as well as elements seeking to penetrate and alter this system, may be identified.

Although in the Marxian sense, the notion of surplus value is usually attached to the production of physical commodities, there is no reason why non-material products (such
as health services) may not be viewed in the same manner (Wright, 1979). And certainly, most aspects of the health care system, ranging from direct patient services to pharmaceuticals are produced in the commodity form. Self-help, then, is certainly removed from this form since, by definition, care and mutual support are exchanged reciprocally, thereby producing no added monetary value in addition to that given or received. Furthermore, self-help does not represent the status quo, but a group seeking changes in the health care system, and their own subordinate position within this system.

Self-help, then, by definition, may threaten the state by challenging state ideology and capitalist social relations in specific areas. If the dominant influences in the health sector are akin to those that the corporate and middle classes have on production (Navarro, 1975), then self-help mirrors the conflicts between labour and capital quite precisely. Even though the current status of capitalism may be more pluralistic than dualistic in nature, a dominant force may be identified. Obviously, though, divergent interests in this area do exist. However,

There is competition, and defeats for powerful capitalist interests as well as victories. After all, David did overcome Goliath. But the point of the story is that David was smaller than Goliath and that the odds were heavily against him. (Navarro, 1975, p.91)

On the other hand, the self-help mode in an albeit constrained manner, at the same time represents a rather attractive proposal. By funding self-help, costs are removed
from the institutional arena, as, in a limited sense, is the
onus, presumably, for the failure of the deinstitutionalization
process. And through the process of contracting out essential
services to local groups, responsibility as well as bureau-
cratic costs are shifted, and in the latter case, reduced. The
result is a cost efficient alternative which, to some degree,
also has the effect of placating other local, grassroots organ-
izations (Fincher and Ruddick, 1983).

Thus it is both logical and favourable to allow the
functioning of self-help in a limited and constrained manner;
while performing essential services, more threatening activities
are, in effect, subdued. Such state intervention allows tol-
erance of the functioning of such groups, yet protects the
interests of dominant, status quo sectors, notably the state,
the medical professionals, and to a lesser extent, the commu-
nity.

From a marxian perspective, then, within the mental
health arena the potential for expanding financial capital would
necessarily be guaranteed through the reproduction of the
mentally ill, as defined by updated medical definitions of
mental illness. Therefore self-help has difficulty in finding
a place within a system that must continually legitimize
existing patterns of dominance over mental health in order to
benefit those with vested interest (vis à vis economic returns)
in the mental health system.

However pertinent may be the observations cited above,
the Marxian framework simply does not address all of the con-
cerns brought about through the broad focus of this research. Although it may be argued that the superstructure of productive relations in capitalist society are timeless as long as the forces of capitalism themselves persist, more recent historical deviations from original Marxian formulations of capitalist societies shed doubt on their applicability to contemporary society. Issues such as the relevance of applying a dichotomous class model to the health care system (although more recent theorists do accommodate a plurality of class interests), for example, have become a point of contention in the context of an apparently increasingly pluralist society the emergence of a distinct and numerically significant middle class, corresponding to a greater proportion of the work force employed in professional and managerial positions may, in fact, indicate a shift from profit seeking as the sole motive of capitalism to control and manipulation of various sectors in society, as implied by Touraine (Giddens, 1973). Also, the omnipotent status ascribed to the relations of production in Marxian theory, even in respect to nonmaterial commodities such as mental health care, further accentuates the questionable validity of this type of reductionism as a sole explanatory framework (Duncan and Ley, 1982). Most notably, Marxist analysis has little to say about bureaucracy in general, and the state in particular, as institutions with social relations which cannot be collapsed to economic imperatives.

Therefore, in light of this present research, one must also look toward the nature of organizations.
Marx's nearly exclusive concern with the productive sphere led him to overlook the possibility that the expropriation of the workers from the means of production was only a special case of a more general phenomenon in modern society where scientists are expropriated from the means of research, administrators from the means of administration, and warriors from the means of violence ... in all relevant spheres of modern society men could no longer engage in socially significant action unless they joined a large scale organization in which they were admitted only upon the condition that they sacrificed their personal desires and predilections to the impersonal goals and procedures that governed the whole. (Coser, 1977, p.232)

This orientation was, in fact, acknowledged by Marx, who noted the increasing complexity of capitalist enterprises as they increased in scale. What emerges, then, is an organization where authority and the accompanying laws become institutionalized. Increasingly, administrative rule, daily routines and organization specific decision-making override private or even executive rule (Wright, 1979), and bureaucracies prevail.

The study of bureaucracies is intrinsic to the work of Max Weber. Both Marx and Weber acknowledged the presence of bureaucracies, and, in fact, their descriptions of the bureaucratic routine differed only minimally. However, while Marx viewed bureaucracy, and especially the alienating characteristic of bureaucracy as a specific product of capitalist production, Weber understood bureaucracy to be a specific form of rationality indicative of the modern form of society, capitalist or socialist (Bell, 1973; Coser, 1977; Giddens, 1971). However, Weber's notion is a pluralistic one. Marx's power is
always rooted in economic grounds. On the other hand, Weber realizes that large scale bureaucratic power is evident on many tiers, and that it can foster the acquisition of measurable economic power to salaried employees (Coser, 1971).

Although not exclusive to capitalism, the link between increasing bureaucratization and capitalist societies is an omnipresent theme found in Weber's writings:

The spread of bureaucracy in modern capitalism is both cause and consequence of the rationalization of law, politics, and industry. Bureaucratization is the concrete, administrative manifestation of the rationalisation of action which has penetrated into all spheres of western culture, including art, music and architecture. The overall trend towards rationalisation in the West is the result of the interplay of numerous factors, although the extension of the capitalist market has been the dominant impetus. (Giddens, 1971, p.183)

Although Weber equates modern bureaucratic form with productive and organizational efficiency, he does demonstrate that it also becomes an antithesis to many of the values common to many western cultures, namely the suppression of individual values and spontaneity. According to Weber, this is merely a product of the highly specialized and technical nature of organizations in modern society, which cannot be significantly circumvented. Therein lies the irrationality of this highly rational organizational mode (Giddens, 1973).

Whereas in pre-modern societies, often personal power reigned, in bureaucratic societies the office, rather than the individual is empowered (Cuzzort and King, 1976). The ideal
bureaucratic form (or "pure type") was characterized by Weber to include the following qualities. Expediency is valued above all, and is accomplished by the pursuing of interests as they are construed by the corporation, and defined in legal terms. Therefore, the office, not the individual is associated with power, and the individual installed in office exercises power only within the confines of his or her corporate tasks. Thus allegiance is to an office, almost exclusively manned by a person holding certified technical knowledge. Finally, all property associated with the office is separated from the individual, as is the "keeping of files", the formal recording of all business accomplished therein (Cuzzort and King, 1976; Giddens, 1971; Ross, 1963).

This ideal form is found mainly only in modern, capitalistic societies. But it is not limited to industry or economic activities per se. And although bureaucratization increases with the size of the organization, neither is it dependent on scope exclusively (Giddens, 1971). In fact,

Since the time of Max Weber, sociologists have regarded bureaucracy as the increasingly 'typical' form of association in modern industrial societies. In countries like the United States Bureaucracy extends from government down through the production of food for our tables to house-cleaning, medical care, and babysitting in many instances. Traditional social groups, such as families and friendship groups, have lost many of their former functions to bureaucratic associations, and institutions like the church and school have become increasingly bureaucratized. (Ross, 1963, p.236)

The mental health system similarly follows a highly
routinized and bureaucratized structure. The myriad of highly specialized individuals possessing advanced technical qualifications form a hierarchy of subordinate and dominant relationships which follows the patterns of the system that have been laid out in an almost (and sometimes, thoroughly) legalistic fashion. As a result, technical and administrative efficiency is maximized, however more often than not, individual concerns have to be renounced (Giddens, 1971).

Conversely, the self-help movement attempts to circumvent these conscripted bureaucratic rules to instead foster a mode of mental health care which bypasses the highly unproductive manner in which the large scale organizations tend to deal with mentally ill patients. Although a notion central to Weber's definition of bureaucracy is the maximization of efficiency, Weber frequently remarks on the dysfunctions of bureaucracy. "Its major advantage, the calculability of results, also makes it unwieldy and even stultifying in dealing with individual cases" (Coser, 1977, p.231).

Thus the self-help movement may be restricted not only by personal or collective economic interests, but by the organizational limits of the officers of the state, local municipalities and medical and mental health institutions. The frustration, powerlessness, and resentment (Ross, 1963) experienced in confronting or gaining exceptions within bureaucracies stems from the tyranny of rules, routines and precedents presented by any bureaucratic organization. It is realized that organizations other than those in the bureau-
ocratic form may be better suited to individual cases, namely self-help groups (Ross, 1963). And those opposed to the application of bureaucratic structures in certain cases are likely to deem them "inefficient only with respect to the goals of the critics, generally the clients" (Ross, 1963, p.257).

As has been documented, the health care system has been difficult to penetrate. According to Giddens (1971, p.182):

...the bureaucratic officialdom has remained in uninterrupted control, and has only been undermined by the total disruption of the social order as a whole. Modern bureaucracy, characterised by a much higher level of rational specialization than patrimonial organizations, is even more resistant to any attempt to prise society from its grip. 'Such an apparatus makes 'revolution', in the sense of the forceful creation of entirely new formations of authority, more and more impossible'"

The self-help movement, therefore, cannot pierce the all-encompassing power of the existing institutions. But as has been demonstrated, the newly emergent self-help groups have frequently become increasingly bureaucratized in their own right. Conformity to acquired rules of client care, albeit often passed on to them by parent bodies (funding institutions, for example) often impose limitations on their own functioning. In particular, overt political action may simply not fit into their own bureaucratic guidelines set into motion to guarantee the efficient day to day functioning and long term survival. For the self-help groups that have developed their own bureaucratic curriculum, out of necessity, an 'authorized' channel for 'non-authorized' activities is simply not available.
In conclusion, one cannot deny the existence of the vested interests of those accumulating capital from the continued operations of the mental health care system as it is currently practised, and therefore the validity of the marxian framework. This, of course, entails the continued market in which to sell the technical expertise of mental health care givers (for example, psychiatrists) and the products of a diverse range of health related industries. Frequently, however, a limited and carefully monitored activity of self-help groups may be allowed to reduce tensions and abate economic strains by siphoning off those clients who contribute difficulties to the successful functioning of established institutions.

However, it must also be recognized that the less than fully successful status of the self-help movement is a product of highly structured, bureaucratic institutions. The groundwork laid by Weber explains much of the curtailment of self-help activities when faced by existing policies, rules and laws. Even in light of the fact that these institutionalized rules may be a direct outgrowth of capitalism, the overriding hurdle to non-conforming groups may simply be their incapacity to penetrate the iron clad bureaucratic institutions they attempt to confront. It must be noted, that in light of Weber's accurate anticipation of socialist bureaucracy, there does exist a logic which is independent of capitalist-socialist distinctions.
CONCLUSION

Conceptually, the self-help movement represents a marked departure from the established institutions of which it forms an integral part. In this study, an array of variables has been introduced, to investigate the obstacles such groups may face in attempting to operationalize models which do not fit into the established institutional configuration. It has been shown that ideals do not necessarily transform into reality, but within the constraints posed by the state, professionals and the community, the obtainable result still renders a workable and effective alternative.

For a study of this scope, however, existing theoretical frameworks represent self-help groups accurately, only when varying perspectives are integrated. This suggests a reformulation of theory, and possibly that a reconsideration of Weber in the context of Marxist literature could provide a possible route in this direction. One should consider the omnipotence of production in Marxist theory which serves to obfuscate all relations other than those between labour and capital. Currently, a critical examination of radical perspectives calls for a further restructuring of theory, and may lead to a rather more eclectic path toward explanation of mental health service provision on all levels.

Concurrently, while mental health self-help groups have focussed on the inequalities between the dominant classes and clients within this arena, perhaps more attention, in light of the current findings both empirically and theoretic-
ally, should be directed towards penetrating existing bureaucratic structures and renegotiating those bureaucratic rules which govern their own organizations in order to achieve goals more relevant to their original mandates that are in addition to service-related provision.

Still, the reality facing the mental patient today remains largely unaltered. Only by understanding the totality of obstacles faced by self-help groups, as well as the problems posed from theory, can viable alternatives confronting existing models of care be established, to deal successfully with mental illness, and indeed all facets of health care and service provision in capitalist society - from a client's point of view.
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APPENDIX 1
MENTAL PATIENTS' DECLARATION OF PRINCIPLES

The following Declaration of Principles was adopted at the Tenth Annual International Conference on Human Rights and Psychiatric Oppression, in Toronto, May 14-18, 1983. (From Phoenix Rising, 5(2-3), 1985, p. 33A.)

1. We oppose involuntary psychiatric intervention including civil commitment and the administration of psychiatric procedures ("treatments") by force or coercion or without informed consent.

2. We oppose involuntary psychiatric intervention because it is an unethical and unconstitutional denial of freedom, due process and the right to be left alone.

3. We oppose involuntary psychiatric intervention because it is a violation of the individual's right to control his or her own soul, mind and body.

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4. We oppose forced psychiatric procedures such as drugging, electroshock, psychosurgery, restraints, solitary confinement, and "aversive behaviour modification".

5. We oppose forced psychiatric procedures because they humiliate, debilitate, injure, incapacitate and kill people.

6. We oppose forced psychiatric procedures because they are at best quackery and at worst tortures, which can and do cause severe and permanent harm to the total being of people subjected to them.

***

7. We oppose the psychiatric system because it is inherently tyrannical.

8. We oppose the psychiatric system because it is an extra-legal parallel police force which suppresses cultural and political dissent.

9. We oppose the psychiatric system because it punishes individuals who have had or claim to had have spiritual experiences and invalidates those experiences by defining
them as "symptoms" of "psychiatric illness".

10. We oppose the psychiatric system because it uses the trappings of medicine and science to mask the social control function it deserves.

11. We oppose the psychiatric system because it invalidates the real needs of poor people by offering social welfare under the guise of psychiatric "care and treatment".

12. We oppose the psychiatric system because it feeds on the poor and powerless, the elderly, women, children, sexual minorities, people of colour and ethnic groups.

13. We oppose the psychiatric system because it creates a stigmatized class of society which is easily oppressed and controlled.

14. We oppose the psychiatric system because its growing influence in education, the prisons, the military, government, industry and medicine threatens to turn society into a psychiatric state made up of two classes: those who impose "treatment" and those who have or are likely to have it imposed on them.

15. We oppose the psychiatric system because it is frighten­ingly similar to the Inquisition, chattel slavery and the Nazi concentration camps.

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16. We oppose the medical model of "mental illness" because it justifies involuntary psychiatric intervention in­cluding forced drugging.

17. We oppose the medical model of "mental illness" because it dupes the public into seeking or accepting "voluntary" treatment by fostering the notion that fundamental human problems, whether personal or social, can be solved by psychiatric/medical means.

18. We oppose the use of psychiatric terms because they substitute jargon for plain English and are fundamentally stigmatizing, demeaning, unscientific, mystifying and superstitious. Examples:

<table>
<thead>
<tr>
<th>PLAIN ENGLISH</th>
<th>PSYCHIATRIC JARGON</th>
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<tbody>
<tr>
<td>Psychiatric inmate..................</td>
<td>Mental patient</td>
</tr>
<tr>
<td>Psychiatric institution............</td>
<td>Mental hospital/mental health center</td>
</tr>
<tr>
<td>Psychiatric system................</td>
<td>Mental health system</td>
</tr>
<tr>
<td>Psychiatric procedure...............</td>
<td>Treatment/therapy</td>
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19. We believe that the people should have the right to live in any manner or lifestyle they choose.

20. We believe that suicidal thoughts and/or attempts should not be dealt with as a psychiatric or legal issue.

21. We believe that alleged dangerousness, whether to oneself or others, should not be considered grounds for denying personal liberty, and that only proven criminal acts should be the basis for such denial.

22. We believe that persons charged with crimes should be tried for their alleged criminal acts with due process of law, and that psychiatric professionals should not be given expert-witness status in criminal proceedings or courts of law.

23. We believe that there should be no involuntary psychiatric interventions in prisons and that the prison system should be reformed and humanized.

24. We believe that so long as one individual's freedom is unjustly restricted no one is truly free.

25. We believe that the psychiatric system is, in fact, a pacification programme controlled by psychiatrists and supported by other mental health professionals, whose chief function is to persuade, threaten or force people into conforming to established norms and values.

26. We believe that the psychiatric system cannot be reformed but must be abolished.

27. We believe that voluntary networks of community alternatives to the psychiatric system should be widely
encouraged and supported. Alternatives such as self-help or mutual support groups, advocacy/rights groups, co-op houses, crisis centers and drop-ins should be controlled by the users themselves to serve their needs, while ensuring their freedom, dignity and self-respect.

***

28. We demand an end to involuntary psychiatric intervention.

29. We demand individual liberty and social justice for everyone.

30. We intend to make these words real and will not rest until we do.

***
This Bill of Rights was drafted in 1983, by ON OUR OWN, a Toronto based self-help group, in order to elucidate the rights of mental patients in Canada, and for use as a tool to pressure their incorporation into the Mental Health Act. A similar Bill of Rights, sponsored by the MENTAL PATIENTS' LIBERATION PROJECT, in New York, has been in effect for over a decade in the United States (reprinted in Mental Patients and the Law, 1: 1973, p.95). (From Phoenix Rising, 5(2-3): p. 35A, 1985)

1. THE RIGHT to remain free of incarceration in any psychiatric facility. Alleged dangerous or criminal acts should be dealt within the criminal justice system.

2. THE RIGHT to due process - the right to a court hearing or trial by jury before incarceration or loss of freedom.

3. THE RIGHT of access to free legal advice, legal counsel or advocacy upon our request.

4. THE RIGHT to be represented by a lawyer of our choice during any or all steps of the civil commitment or admission process, Review Board or Advisory Board hearing.

5. THE RIGHT to remain silent during civil commitment or admission to any psychiatric facility.

6. THE RIGHT to be warned that information communicated to a psychiatric staff during examination for civil commitment or admission to a psychiatric facility is not privileged or confidential.

7. THE RIGHT to refuse any psychiatric treatment - whether as a voluntary or involuntary inmate - without threat, reprisal or coercion of any kind.

8. THE RIGHT to refuse to be labelled or diagnosed since psychiatric diagnostic terms (e.g. "mentally ill", "schizophrenic", etc.) are unscientific, invalid, mystifying and stigmatizing.

9. THE RIGHT to informed consent to any treatment - the right to be fully informed by a doctor about: a. the
nature and type of any treatment(s) planned for us; b. the major effects and alleged benefits of the treatment(s); c. the known side-effects, adverse reactions or risks of the treatment(s); and d. the known and safe alternative(s) to the treatment(s) — before giving our consent. To be valid, our consent must also be freely given without any external pressure, threat or coercion.

10. THE RIGHT to refuse to participate in any research or teaching program while incarcerated.

11. THE RIGHT to be fully informed within 24 hours of admission, about institutional rules and regulations and about our legal rights, including the right to a review board or court hearing. This information must be in plain language which we can read and understand.

12. THE RIGHT to wear our own clothes at any time while incarcerated.

13. THE RIGHT to sanitary and humane living conditions while incarcerated.

14. THE RIGHT to choose our own doctor or therapist while incarcerated.

15. THE RIGHT to consult with any doctor, therapist or community mental health worker not affiliated with the psychiatric institution, unit or ward in which we are incarcerated.

16. THE RIGHT to immediate and competent medical treatment by a doctor of our own choice upon request.

17. THE RIGHT to be provided with nutritious food, including a vegetarian or kosher diet if we request it.

18. THE RIGHT to refuse to participate in any activity or program in any psychiatric facility without threat, reprisal or coercion of any kind.

19. THE RIGHT to uncensored communication by telephone, letter or in person with whomever we wish at all reasonable times.

20. THE RIGHT to complete confidentiality of our medical and psychiatric records.

21. THE RIGHT of access to our own medical and psychiatric records, including the right to see, copy and/or correct any part of these records.
22. THE RIGHT to be paid not less than the minimum wage for any work we have performed for the institution. Such work shall include any task(s) performed in any so-called "industrial therapy" or "vocational rehabilitation" program or "sheltered workshop".

23. THE RIGHT to vote in any municipal, provincial and federal election, including the right to be enumerated and fully notified of the date, time and place of voting, and assistance in travelling to the polling place upon our request.

24. THE RIGHT to be provided with adequate financial assistance while incarcerated and upon leaving any psychiatric facility.

25. THE RIGHT to manage our own money and retain our personal possessions while incarcerated.

26. THE RIGHT to be informed of available housing alternatives and to be assisted in finding adequate and affordable housing in the community before our release from any psychiatric facility.

27. THE RIGHT not to be subjected to any form of cruel and unusual treatment or punishment, as guaranteed under the Canadian Charter of Rights and Freedoms and the United Nations' Universal Declaration of Human Rights.

28. THE RIGHT to sue any psychiatric facility or staff member(s) for any physical abuse, assault, forced treatment or violation of our civil, legal or constitutional rights which we have suffered while incarcerated.

29. THE RIGHT to be treated with dignity and respect at all times.

30. THE RIGHT to control our own body, mind and life.
APPENDIX III

INTERVIEW (1) SKELETAL QUESTIONS

A. GENERAL QUESTIONS

1. Perhaps we could start by outlining exactly what (name of group) does, and what needs you fill.

2. What, if any, is the central philosophy of _________? What are the goals of _________?

3. Who are your clients? May anyone participate; must they be referred by a physician or agency, or are there other criteria which must be met in order to become an active participant of _________?

Does there exist a typical client profile? (For example, in terms of family status, socio-economic status, age, etcetera?)

B. SELF-HELP

4. What is the organizational structure of _________? Who participates in the running and governing of _________?

5. To what extent are psychologists, psychiatrists, social workers or other professionals employed in operating your programs?

6. A central philosophy of many self-help groups involves the notion that those who have gone through 'rough times' themselves are qualified to help others going through similar experiences. Is this philosophy reflected in _________?

To what extent do you feel that non-professionals can provide help (For example, as a replacement for professionals, in the short term, in the long term)?

7. Conversely, in the eyes of _________ when should the professional step in, in the situations you deal with, and take control, if ever?

8. Have you encountered any feedback, positive or negative, from the psychiatric community of the approaches followed here?
C. FUNDING

9. What are the sources of funding for _________? Perhaps you could give a brief history.

10. Have any of the funding sources, such as _________ stipulate additional regulations or constraints on the programs that _________ must comply with? (If so, ask for description.)

IF YES: From the point of view of the philosophy of _________, were these stipulations beneficial or detrimental to the operation here?

11. Have the directions or objectives have to change in any way to accommodate any funding regulations?

D. COMMUNITY

12. Do you consider _________ to be (a) visible facility/facilities to the surrounding community?

Is this high/low level of visibility important?

13. Have you experienced any difficulties, opposition or general unease about the facility from the surrounding community?

14. Have city zoning bylaws produced any difficulties in locating this facility?

IF YES: Give details.

E. THE SELF-HELP MOVEMENT

15. Do you feel that _________ is a part of the broader self-help movement?

IF YES: What ties do you hold with the movement? (For example, newsletter, participation in conferences, etc.)

16. Have the participants in _________ participated in any legal or political action with respect to any aspect of your activities or ideology? This may, for example, include involvement in changing zoning bylaws, the Mental Health Act, and so on.

17. Self-help has sometimes been characterized as a 'political' movement (in terms of changing the balance of power, especially within the health care system). Would you characterize the _________, or the participants of _________ as being essentially political?
F. ASSESSMENT

18. Generally, what is your assessment of the development and programs of __________, with respect to both the impacts it has had on those participating, and also the fulfillment of your goals.

19. If a trend is visible, how would you characterize the changes that have occurred since the formation of __________?

How would you account for these changes?

20. What changes, if any, would you like to see in the future?

21. How would you estimate your effect on the patterns of service and mental health care delivery in British Columbia in general. In your opinion, has __________ and other groups had much impact in this respect?

22. Do you have any comment on any topics we may not have covered to this point? Any concluding comments?

Thank you very much.
APPENDIX IV
MENTAL PATIENTS' ASSOCIATION QUESTIONNAIRE

This is a survey to help find out a little more about the MPA. Taking a few minutes to complete this will be very much appreciated, and will give us a lot of information about the MPA. Most of the questions can be answered with a check or just a few words, but please feel free to write as much or as little as you want for any of the questions. Thank you very much!

1. How did you first find out about the MPA? (Please check ✓)
   - friend
   - doctor
   - social worker
   - magazine or newspaper
   - other _______________________

2. Why did you start coming to the MPA? (Please check ✓)
   - knew someone here
   - referred by doctor or agency
   - just decided to drop by
   - other reason _______________________

3. What, in your opinion, are the most important things about the MPA? (Please check ✓ any item or items you think are most important.)
   - help you find a place to live
   - meet friends
   - talking to other people about your experiences
   - help you find a job
   - somewhere to go

4. Is there anything that ISN'T on this list you think is important?
5. How often do you visit the drop-in? (Please check \(\checkmark\) one)
   - less than once a week
   - a few times a week
   - many times a week
   - every day

6. WHY do you go to the MPA drop-in?

7. Approximately HOW LONG have you been coming to the MPA? (Please check \(\checkmark\) one)
   - more than 1 year
   - 7 to 12 months
   - 2 to 6 months
   - less than 2 months

8. Do you live in MPA housing?
   - No
   - Used to, but not anymore
   - Yes

   If you once lived in MPA housing, why don't you now?
   - boarding house
   - MPA apartment

   If you have lived in, or are now living in MPA housing, what are the reasons you chose to live there?

9. What are the BEST things about the MPA?

10. What DON'T you like about the MPA?
11. Is there something special about the MPA that you can't find anywhere else?

12. Do you think the MPA has helped you from having to go back to Riverview or another hospital?
   _____ No    _____ Yes    _____ Not applicable
   IF YES? How? ______________________

13. All in all, how helpful has the MPA been to YOU?
    (Please check ✓ one)
    _____ extremely helpful
    _____ very helpful
    _____ some help
    _____ not very helpful
    _____ not at all helpful

13 Do you know about the Mental Patients' Movement (mental patients' charter of rights, conferences, lobbying, etc.)?
   _____ yes
   _____ no

15. Have you ever been involved with the Mental Patients' Movement?
   _____ yes
   _____ no
   If YES, how?

16. Do you think groups like the MPA should be involved in the Mental Patients' Movement?
   _____ yes
   _____ no
   _____ don't know
17. What, if any, changes would you like to see in psychiatric hospitals, of psychiatrists, etc.?

18. Is there anything else you would like to say about the MPA, this questionnaire, psychiatrists, or other topic?

THANK YOU!