Mental Health Self-Help
Dedicated to mental health consumers and family members who inspired us, Greg Meissen who mentored us, and our families who supported us.
We would like to thank the thousands of research participants who have enabled the study of mental health self-help to progress. This book serves as a distillation of their input. We would also like to express our gratitude towards all of the chapter authors, who politely endured and accommodated our sometimes relentless requests for revisions. The quality of the finished product reflects their outstanding efforts. Finally, we would like to thank Springer for making this book possible and Sharon Panulla for shepherding us through the book publication process.
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Contributors

Adrienne Banta  Center for Community Support and Research, Wichita State University, Wichita, KS, USA, anbanta@wichita.edu

Chris Barker  Department of Clinical, Educational and Health Psychology, University College London, London, UK, c.barker@ucl.ac.uk

Crystal R. Blyler  SAMHSA Center for Mental Health Services, Rockville, MD, USA, crystal.blyler@samhsa.hhs.gov

Louis D. Brown  Prevention Research Center, The Pennsylvania State University, State College, PA, USA, ldb12@psu.edu

Neal B. Brown  Community Support Programs Branch, SAMHSA Center for Mental Health Services, Rockville, MD, USA, neal.brown@samhsa.hhs.gov

Wai-Tong Chien  The School of Nursing, Faculty of Health & Social Sciences, The Hong Kong Polytechnic University, Hong Kong SAR, China, chinwaton@yahoo.com.hk; hschien@inet.polyu.edu.hk

Oliwier Dziadkowiec  Center for Community Support and Research, Wichita State University, Wichita, KS, USA, oliwier.dziadkowiec@wichita.edu

Jerry Finn  Social Work Program, University of Washington, Tacoma, WA, USA, finnj@u.washington.edu

Daniel Fisher  National Empowerment Center, Lawrence, MA, USA, daniefisher@gmail.com

Risa Fox  SAMHSA Center for Mental Health Services, Rockville, MD, USA, risa.fox@samhsa.hhs.gov

Emily A. Grant  Center for Community Support and Research, Wichita State University, Wichita, KS, USA, emily.grant@wichita.edu

Keith Humphreys  Department of Psychiatry, Stanford University Stanford, CA, USA, knh@stanford.edu

Rich Janzen  Center for Community Based Research, Kitchener, ON, Canada, rich@communitybasedresearch.ca
Contributors

Ashlee Keele-Lien  Center for Community Support and Research, Wichita State University, Wichita, KS, USA, ashlee.keele-lien@wichita.edu

Alicia Lucksted  Center for Mental Health Services Research, Division of Services Research, Department of Psychiatry, University of Maryland School of Medicine, Baltimore, MD, USA, aluckste@psych.umd.edu

Greg Meissen  Department of Psychology, Wichita State University, Wichita, KS, USA, greg.meissen@wichita.edu

Geoffrey Nelson  Department of Psychology, Wilfrid Laurier University, Waterloo, ON, Canada, gnelson@wlu.ca

Joanna Ochocka  Centre for Community Based Research, Kitchener, ON, Canada, joanna@communitybasedresearch.ca

Brian E. Perron  School of Social Work, University of Michigan, Ann Arbor, MI, USA, beperron@umich.edu

Nancy Pistrang  Department of Clinical, Educational and Health Psychology, University College London, London, UK, n.pistrang@ucl.ac.uk

Thomas J. Powell  School of Social Work, University of Michigan, Ann Arbor, MI, USA, tpowell@umich.edu

Katie W. Randall  Washington State Department of Social and Health Services, Olympia, WA, USA, weavek@dshs.wa.gov

Crystal Reinhart  Center for Prevention Research & Development, University of Illinois at Urbana-Champaign, Champaign, IL, USA, reinhrt@illinois.edu

Thomas M. Reischl  Prevention Research Center of Michigan, University of Michigan School of Public Health, Ann Arbor, MI, USA, reischl@umich.edu

Susan Rogers  National Mental Health Consumers’ Self-Help Clearinghouse, Philadelphia, PA, USA, srogers@mhasp.org

Deborah A. Salem  Department of Health Behavior & Health Education, University of Michigan School of Public Health, Ann Arbor, MI, USA, debbysalem@gmail.com

Mark S. Salzer  Department of Psychiatry, University of Pennsylvania, Philadelphia, PA, USA, mark.salzer@uphs.upenn.edu

Todd Shagott  Center for Community Support and Research, Wichita State University, Wichita, KS, USA, tpshagott@gmail.com

Lauren Spiro  National Coalition of Mental Health Consumer/Survivor Organizations, Washington, DC, USA, laurenspiro1@gmail.com

T. Steele  MSW student, University of Washington, Tacoma, USA, steelet@u.washington.edu
Nathan Swink  Center for Community Support and Research, Wichita State University, Wichita, KS, USA, npswink@wichita.edu

John Trainor  Department of Psychiatry, University of Toronto, Toronto, ON, USA, john_trainor@camh.net

Chi Connie Vu  James Bell Associates, Washington, DC, USA, vu@jbassoc.com

Scott Wituk  Center for Community Support and Research, Wichita State University, Wichita, KS, USA, scott.wituk@wichita.edu
About the Editors

**Louis D. Brown** is a community psychologist and research faculty member of The Pennsylvania State University. His research examines how people engage in and benefit from self-help/mutual support initiatives. As a research associate at the Penn State Prevention Research Center, Dr. Brown also studies community health partnerships and the implementation of evidence-based programs to promote healthy youth development.

**Scott Wituk**, PhD, is the director of the Center for Community Support and Research (CCSR) at Wichita State University. Previously he served as the research coordinator at CCSR. In these positions he has conducted community-based research projects with self-help groups, coalitions, nonprofits, and other community-based organizations. He has over 30 peer-reviewed publications and book chapters and numerous professional presentations.
About the Authors

**Adrienne Banta** has a bachelor’s of science in psychology from Wichita State University. She currently works at the Center for Community Support and Research as a research assistant. Her research interests include evaluating consumer-run organizations, as well as conducting needs assessments and program evaluations for a variety of other nonprofit organizations.

**Chris Barker** is a reader in clinical psychology at University College London. He received his PhD in clinical psychology from UCLA. His research focuses on the communication of psychological helping and support, in a variety of clinical and community contexts, and he also publishes on research methodology.

**Crystal R. Blyler** is a social science analyst for the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). She was the co-program leader for the Consumer-Operated Services Program (COSP), a multi-site randomized trial of consumer-operated services, and the government project officer for the development of a Consumer-Operated Services Evidence-Based Practice KIT. Prior to joining SAMHSA in 1999, she received a PhD in experimental psychopathology from Harvard University and worked as a schizophrenia researcher.

**Neal B. Brown**, M.P.A. has been a national leader on policy and program issues in mental health and since 1983 has directed the Federal Community Support Program (CSP), a national program and movement designed to promote and advocate for community treatment, rehabilitation, employment, and opportunities for individuals with psychiatric disabilities. He also currently directs a national initiative focused on transforming and reforming state and community mental health systems to better emphasize consumer direction, empowerment, and recovery.

**Wai-Tong Chien** is associate professor in the School of Nursing, Faculty of Health and Social Sciences, The Hong Kong Polytechnic University of Hong Kong S.A.R., China. He has published widely on mental health issues and psychosocial interventions for clients with physical and mental health problems and their family members, using both quantitative and qualitative research methods. He has also committed to the development of education curriculum, licensure, and practice guidelines of psychiatric/mental health nursing in the Nursing Council of Hong Kong.
Oliwier Dziadkowiec is a doctoral student in the Department of Community Psychology at Wichita State University and is a research associate at the Center for Community Support and Research. His research interests include evaluation of the impact of consumer-run organizations and other consumer-based initiatives, the impact of social capital on various health related outcomes, as well as the use of systemic methods in public health and public policy research.

Jerry Finn, PhD is currently a professor in the Social Work Program, University of Washington, Tacoma. Dr. Finn has 30 years of teaching experience in social work that includes courses in human behavior, research, practice, and information technology and human services at the bachelors and masters levels, and has served on doctoral committees. In addition he has published many scholarly articles and two edited books, primarily in areas related to the impact of information technology on human services. In addition, Dr. Finn has provided training and consultation to human service agencies in the areas of digital divide intervention, child welfare programs, consumer satisfaction, online hotlines, and program evaluation.

Daniel Fisher, MD, PhD has devoted his life to bringing hope and recovery to the lives of those labeled mental illness through his work as a board-certified, community psychiatrist who works at Riverside Community Care, a neurochemist who worked on neurotransmitters at the NIMH, an advocate who has recovered from schizophrenia and directs the National Empowerment Center, and as a member of the White New Freedom Commission on Mental Health.

Risa Fox is a public health advisor for the U.S. Substance Abuse and Mental Health Services Administration. She is the GPO on an Interagency Agreements with the Department of Educational, National Institute on Disability and Rehabilitation for two currently funded adult Rehabilitation, Research, and Training Centers. Ms. Fox is the program director for the Consumer & Consumer-Supporter National Technical Assistance Centers on Consumer/Peer-Run Programs and previous GPO of the Statewide Consumer Network Grantee Program. She previously held positions at the National Institute of Mental Health working with the Community Mental Health Centers (CMHCs) Program and worked with CMHS at regional and local levels. She is a licensed psychiatric social worker and holds an MS degree from Columbia University.

Emily A. Grant is a doctoral student in the Department of Community Psychology at Wichita State University and conducts research and evaluation at the Center for Community Support and Research. Her current research interests include evaluation of the certified peer specialist program in Kansas and integration of certified peer specialists into the mental health system.

Keith Humphreys is a professor of psychiatry and behavioral sciences at Stanford University and a VA senior research career scientist. A clinical/community psychologist by training, his research focuses on the prevention and treatment of addictive disorders, and on the extent to which subjects in medical research differ from patients seen in everyday clinical practice. Since 2004, he has also volunteered as
a consultant and teacher in the multinational effort to rebuild the psychiatric care
system of Iraq, for which he recently won the American Psychological Association’s
Award for Distinguished Contribution to the Public Interest. Dr Humphreys has been
extensively involved in the formation of federal drug control policy.

Rich Janzen is research director at the Centre for Community Based Research and
a doctoral candidate in community psychology at Wilfrid Laurier University. Rich
has been involved in over 70 participatory action research projects, most focusing
on issues of cultural diversity or mental health. Rich lives in Waterloo, Ontario.

Ashlee Keele-Lien is a doctoral student in the community psychology program
at Wichita State University. Her research interests involve empowerment within
marginalized communities. Her current research is focused on mental health
consumer perceptions of Certified Peer Specialists.

Alicia Lucksted is a clinical-community psychologist and assistant professor of
psychiatry at the University of Maryland School of Medicine, Center for Mental
Health Services Research. Her work focuses on applied research to improve men-
tal health services for people with serious mental illnesses, self-help interventions
among mental health consumers and their family members, qualitative methods in
mental health services research, and consumer views of mental health services.

Greg Meissen is professor of psychology at Wichita State University, has had fac-
culty appointments at Harvard Medical School and Boston University, and served on
the newly founded Self-Help Network to WSU where he served as director until
2008 as it grew into the nationally recognized Center for Community Support and
Research where he was involved in projects focused on capacity building of com-
munity and faith-based organizations, development of self-help and mutual support
organizations particularly mental health consumer-run organizations, and initia-
tives to promote community leadership. This work was funded by grants he was
awarded from numerous agencies including the National Institute of Mental Health,
Substance Abuse and Mental Health Services Administration, Center for Mental
Health Services Research, and WT Grant Foundation, and he has published this
research in such outlets as the New England Journal of Medicine, American Journal
of Community Psychology, Social Work, Journal of Applied Behavioral Science,
Journal of Community Psychology and Psychiatric Services.

Geoffrey Nelson is professor of psychology at Wilfrid Laurier University, Waterloo,
Ontario, Canada. He has served as senior editor of the Canadian Journal of
Community Mental Health and Chair of the Community Psychology Section of the
Canadian Psychological Association. Professor Nelson was the recipient in 1999
of the Harry MacNeill award for innovation in community mental health from the
American Psychological Foundation and the Society for Community Research and
Action of the American Psychological Association.

Joanna Ochocka (PhD sociology) is executive director of the Centre for
Community Based Research and adjunct faculty member in the Department of
Sociology at University of Waterloo and in the MA and PhD program in community psychology at Wilfrid Laurier University in Waterloo, Ontario, Canada. Joanna is one of the leaders in the use of participatory action research approach and she practices community-based research as a tool to mobilize people for social change. Joanna’s research and action have focused on community mental health for people with serious mental health issues, on cultural diversity and immigration, and on community supports for marginalized populations.

**Brian E. Perron** is an assistant professor at the University of Michigan, School of Social Work. He received his PhD in social work from Washington University in 2007. His research focuses on problems associated with psychiatric and substance use disorders.

**Nancy Pistrang** is a reader in clinical psychology at University College London. She received her PhD in clinical psychology from UCLA, after which she worked as a clinical psychologist in the British National Health Service before taking up her present position. Her research focuses on psychological helping in everyday relationships, including peer support, communication in couples, and mutual support groups.

**Thomas J. Powell**, MSW, PhD is professor of social work, University of Michigan. His research interests are in the area of mental health services for people with serious mental illness. He has a particular interest in self-help, support, and advocacy groups with a special emphasis on how these mutual help resources can be coordinated with professional care.

**Katie W. Randall** received her MA in community psychology from Michigan State University in 2000. She worked as a research investigator for the Washington Institute for Mental Health Research and Training at the University of Washington and Washington State University from 2001–2007. In this position, she contracted with the Mental Health Division of Washington State to conduct mental health services research and evaluation. She currently works for the Washington State Department of Social and Health Services as a management analyst where she provides assistance with planning, performance management, and accountability.

**Crystal Reinhart** is a doctoral student in the Community Psychology program at Wichita State University. Ms. Reinhart’s doctoral research is focused on mental health consumer-run organizations, and her research interests have also included Certified Peer Specialists and other consumer initiatives. She is currently working on substance abuse prevention and teen parenting at the Center for Prevention Research and Development at the University of Illinois.

**Thomas M. Reischl** is an associate research scientist in the Department of Health Behavior and Health Education at University of Michigan’s School of Public Health. He received a PhD in psychology from the University of Illinois and has held previous faculty appointments at Michigan State University, the University of New Hampshire, and the University of Waikato (New Zealand). In his current position, he serves at the Director of Evaluation for the Prevention Research
Center of Michigan and conducts evaluation research studies of community-based public health programs, violence prevention programs, family support programs, consumer-controlled (self/mutual help) programs, and public-health preparedness programs.

Susan Rogers is director of the National Mental Health Consumers’ Self-Help Clearinghouse, a mental health consumer-run national technical assistance center funded by a grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. She is also director of special projects of the Mental Health Association of Southeastern Pennsylvania. She has 33 years of experience as a writer and editor, and she has been active in the mental health consumer/survivor movement since 1984.

Deborah A. Salem received her PhD from the University of Illinois at Urbana-Champaign. Her research has focused on mutual help for individuals with serious mental illness, adoption of innovation, and organizational development. After 17 years on the faculty in the Department of Psychology at Michigan State University, she is currently teaching as a lecturer at the University of Michigan and doing research consultation.

Mark S. Salzer received his PhD in clinical/community psychology at the University of Illinois at Urbana-Champaign. He is an associate professor in the Department of Psychiatry at the University of Pennsylvania and an investigator in the Mental Illness Research, Education, and Clinical Center based at the Philadelphia VA Medical Center. Dr. Salzer’s research focuses on the delivery of effective community mental health and rehabilitation services to individuals with psychiatric disabilities, with a particular focus on identifying and eliminating barriers to full community participation, promoting effective utilization of mainstream community resources, and enhancing the development and effectiveness of support initiatives (e.g., peer, employment, education, and natural supports).

Todd Shagott recently received his doctorate degree from the Community Psychology Program at Wichita State University. His interests are in evaluation, behavior setting theory, and working with nonprofit organizations. Most recently his research evaluated how the setting characteristics of consumer-run organizations promoted positive health behaviors.

Lauren Spiro, MA, is director of the National Coalition of Mental Health Consumer/Survivor Organizations, and co-director of the Education for Social Inclusion Project funded by the Substance Abuse and Mental Health Services Administration. She has traveled a liberating journey to wellness from her being labeled with ‘chronic schizophrenia’ to devoting her life’s works to building emotionally healthy communities. She co-founded two nonprofit corporations and as the director of the National Coalition of Mental Health Consumer/Survivor Organizations, she advances the values, vision, policies, and legislative priorities of mental health consumers in Washington, D.C. and across the country.
T. Steele is currently a graduate student in social work at the University of Washington Tacoma. She holds a BA in communication with an emphasis in communication technology and society from the University of Washington Seattle.

Nathan Swink received a masters degree in 2007 at Wichita State University in Wichita, KS, where he is currently pursuing a PhD in community psychology. His research focuses on ways the underlying assumptions and cognitive processing styles of individuals take form in communities. Living downtown, he is both physically and politically active in Wichita communities.

John Trainor has had a long-standing interest in self-help and consumer/survivor-run organizations. He led the initial development of over 40 of these groups in Ontario, Canada in the 1990s. He has also worked internationally and supported the development of groups in the Baltic states and Sri Lanka.

Chi Connie Vu received her MA in community psychology from Wichita State University in 2006. She has 5 years of experience in applied social science research design, program evaluation, grant writing, and capacity building technical assistance. As a senior staff member at James Bell Associates (JBA), Ms. Vu currently provides evaluation technical assistance to discretionary grant programs funded by the Administration for Children and Families. Prior to joining JBA, Ms. Vu was a research associate at the Wichita State University Center for Community Support and Research where she conducted research for a jointly funded National Institute of Mental Health and Substance Abuse and Mental Health Services Administration project on promoting effective practices among mental health consumer-run organizations.
Chapter 1
Introduction to Mental Health Self-Help

Louis D. Brown and Scott Wituk

Abstract Mental health self-help (MHSH) refers to any mutual support-oriented initiative directed by people with mental illness or their family members. These initiatives have become increasingly widespread over the years and today MHSH initiatives outnumber traditional mental health organizations in the United States (Goldstrom et al., 2006). The goal of this book is to provide research-based insight into the development of effective MHSH initiatives. This chapter explores the defining characteristics of MHSH and reviews its historical development. Building on this foundation, the chapter examines several factors contributing to the growth and popularity of MHSH, along with an exploration of factors impeding the use of MHSH. Following is a discussion of future directions for research and practice. Finally, the chapter provides a summary of the topics covered by each subsequent chapter.

This book brings together leading research across many different types of mental health self-help (MHSH) initiatives. Drawing from both existing research and experiential knowledge, each chapter provides insight into the development of effective MHSH initiatives. These insights will be useful to leaders of MHSH initiatives, mental health researchers, state and local administrators, and professionals who work with consumer and family-driven initiatives. Furthermore, students planning careers in mental health can use this book to understand an important approach to recovery from mental illness that is growing in popularity and utilization. Finally, leaders of MHSH initiatives can use the evaluation studies reviewed in this book to provide evidence for the effectiveness of MHSH.

Overall, the edited volume contains fifteen chapters addressing the development of effective MHSH initiatives. In addition to this introductory chapter, which outlines the field of MHSH, the book provides chapters exploring mutual-help groups for mental health problems, mutual-help groups for caregivers, consumer-run drop-in centers, online self-help, and consumer advocacy initiatives. Technical assistance

L.D. Brown (✉)
Prevention Research Center, The Pennsylvania State University, 135 E, Nittany Ave, Suite 402, State College, PA 16801, USA
e-mail: ldb12@psu.edu
organizations and peer support specialist initiatives are examined separately at the national level, with additional chapters on these two topics providing a more in-depth exploration of their implementation at the state level. The book also provides two chapters discussing collaboration with the professional mental health system, two chapters discussing theoretical frameworks for MHSH practice and research, and one chapter sharing the perspective of funding organizations interested in supporting MHSH. Before providing a more detailed summary of each chapter, the following sections explore (1) the terminology of MHSH, (2) the history of MHSH, and (3) factors influencing the use of MHSH.

1.1 MHSH Terminology

The term self-help broadly refers to any self-directed undertaking aimed at personal improvement. In this book, however, we specifically focus on collaborative efforts directed by mental health service consumers or their family members. These initiatives typically target mental health promotion goals such as enhanced coping and progress toward recovery. The degree to which mental health professionals influence organizational decision making varies substantially; however consumers and family members control final decision making. Considerable variation exists within these definitional boundaries and this book considers some of the most popular types of MHSH, including mutual-help groups (also known as self-help/mutual aid/mutual support groups), consumer-run drop-in centers, certified peer specialist programs, technical assistance organizations, advocacy organizations, and online self-help mutual aid groups. Other types of initiatives exist and several terms in the literature describe MHSH initiatives, including

- mutual-help groups (e.g., Corrigan et al., 2005)
- mutual support groups (e.g., Chien, Norman, & Thompson, 2006)
- mutual aid groups (e.g., Kelly, Salmon, & Graziano, 2004)
- self-help groups (e.g., Burti et al., 2005)
- consumer-run organizations (e.g., Brown, Shepherd, Wituk, & Meissen, 2007)
- consumer/survivor initiatives (e.g., Nelson, Lord, & Ochocka, 2001)
- consumer drop-in centers (e.g., Mowbray, Robinson, & Holter, 2002)
- consumer-operated self-help centers (e.g., Swarbrick, 2007)
- self-help agencies (e.g., Segal & Silverman, 2002)
- peer-run organizations (e.g., Clay, 2005)
- consumer-run businesses (e.g., Kimura, Mukaiyachi, & Ito, 2002)
- self-help programs (e.g., Chamberlin, Rogers, & Ellison, 1996)
- consumer-delivered services (e.g., Salzer & Shear, 2002)
- consumer-run services (e.g., Goldstrom, 2006).

Although the broad variety MHSH initiatives do not fit neatly into a small number of categories, two organizational characteristics that help to classify MHSH initiatives are organizational structure and organizational focus. Locating a MHSH
initiative on the continuum of organizational structure and the continuum of organizational focus provides insight into the nature of its operations and the outcomes of its efforts.

Self-help groups exemplify the unstructured end of the organizational structure continuum, which is also characterized by the informal nature of interpersonal relations and a reliance on volunteer contributions from group members for all group activities. Highly structured MHSH initiatives that rival the organizational complexity of psychiatric hospitals and other formal agencies operated by paid staff do not yet exist. However, consumer-operated services such as certified peer specialist training programs and crisis residential services rely on paid staff and maintain substantially more structure than self-help groups. Some MHSH initiatives, such as consumer-run drop-in centers, rely on a mixture of paid and volunteer support and typically fall in the middle of the continuum of organizational structure.

It is important to understand the strengths and weaknesses of different organizational structures because the structure of a MHSH initiative typically evolves over time and needs to be strategically managed. As MHSH initiatives grow, they are likely to face pressure to adopt a more formal organizational structure. However, adding organizational structure to manage growth can have devastating unintended consequences as the advantages of unstructured initiatives are lost (Smith, 2000).

Unstructured groups lack role differentiation, which enables informal, highly personalized interactions between group members that are typically warmer, more encouraging, and more accepting (Wuthnow, 1994). Smaller initiatives are also better able to promote the investment and involvement of all participants because all contributions are needed and consensus-driven decision making is feasible. The lack of hierarchy and bureaucracy encourages mutual support, intimacy, and sharing. Relying exclusively on internal funding also ensures independent control over organizational activities and prevents cooptation by external funding agencies (Brown et al., 2007).

Although small informal organizations manifest several characteristics that promote MHSH success, developing organizational structure also has several advantages. Large organizational size and hierarchical role differentiation enables economies of scale, which are more efficient at the production of goods and the provision of services (Milofsky, 1988). Obtaining external funding allows MHSH initiatives to pursue activities and programs that cannot be accomplished otherwise. The role specialization and clear chain of command that accompany a structured organization can help promote efficient, goal-focused interactions and rapid organizational decision making. Training and certification requirements help to ensure paid staff members possess the skills necessary to fulfill role expectations. Although these characteristics of structured organizations are frequently necessary for MHSH initiatives to become effective service providers, they can also weaken the effectiveness of mutual support, which thrives in unstructured settings. Furthermore, there is concern that paying consumers to help other consumers will reproduce power inequities that currently exist in the professional mental health system. Regardless, using consumers as service providers can help to address the
poverty-level conditions experienced by many mental health consumers and may help to build stronger therapeutic alliances (Solomon, 2004).

Organizational focus is another characteristic that can aid the classification of MHSH initiatives. Initiatives with an internal focus on helping members fall at one end of the continuum and externally focused initiatives that target changes in mental health policy and the broader community fall at the opposite end of the continuum. MHSH has traditionally focused on internal change, with members helping one another progress toward recovery. In fact, initiatives that are purely focused on external change are not traditionally conceptualized as part of self-help (Humphreys, 2004). However, initiatives that maintain both internal and external goals remain under the MHSH umbrella. For example, consumer-run drop-in centers often make presentations in the community to enhance education about mental illness. Consumer coalitions that directly target mental health policy changes also frequently invest in improving the leadership skills of their members. Understanding the focus of a MHSH initiative enables the specification of appropriate indicators of success. Success for internally focused initiatives may be indicated by the enhanced well-being of participants whereas the success of externally focused initiatives may be improvements in mental health policy or reduced stigma toward mental illness in the community.

1.2 History of MHSH

Over the past century, mental health treatment has seen drastic transformations and today a new philosophy is emerging in community mental health called the empowerment-community integration paradigm (Nelson et al., 2001). Table 1.1 provides a historical context for understanding the evolution of mental health treatment and how the empowerment-community integration paradigm differs from traditional treatment paradigms (Nelson et al., 2001).

One of the earliest approaches to mental health treatment is the medical-institutional paradigm, which became dominant in the nineteenth century. This paradigm emphasized the use of psychiatric hospitals constructed to treat patients who had little, if any, control in determining their treatment. During the 1960s, the community treatment-rehabilitation paradigm emerged, providing alternatives to institutionalization that included supportive housing, clubhouses, case management, and other services designed to provide clients life skills so they would require reduced amounts of professional care, especially hospitalization. While a significant advance, a number of issues in the community treatment-rehabilitation paradigm remain, including a focus on individual deficits leading to continued stigma and an imbalance of control between professionals and consumers (Carling, 1995; Nelson et al., 2001). Studies have found that the community treatment-rehabilitation paradigm helped many people have a physical presence in the community while remaining socially and psychologically unintegrated (Mowbray, Greenfield, & Freddolino, 1992; Sherman, Frenkel, & Newman, 1986).
Introduction to Mental Health Self-Help

Table 1.1 Changing paradigms in community mental health

<table>
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<th>Traditional paradigms</th>
<th>Community treatment-rehabilitation</th>
<th>Emerging paradigm</th>
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<tr>
<td>Medical-institutional</td>
<td></td>
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<tr>
<td>Lack of consumer voice and choice</td>
<td>Consumers have input but professional retains control</td>
<td>Self-directed collaboration with professionals</td>
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<td>Dependence on professionals</td>
<td>Dependence on professionals</td>
<td>Autonomous consumer-run organizations</td>
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<td>Patient role</td>
<td>Client role</td>
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<td>Professional role as expert</td>
<td>Professional role as expert</td>
<td>Professional role focuses on collaboration and enabling</td>
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<td>Professional services</td>
<td>Professional, paraprofessional, and volunteer services</td>
<td>Self-help/mutual support, informal supports</td>
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<td>Institutional locus</td>
<td>Community-based locus</td>
<td>Integration into community settings and social support networks</td>
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<td>Stigma, focus on illness</td>
<td>Stigma, focus on psychosocial deficits</td>
<td>Focus on strengths, potential for growth and recovery</td>
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Note: From Nelson et al. (2001)

The empowerment-community integration paradigm is now beginning to emerge in response to many of the weaknesses inherent in the community treatment-rehabilitation paradigm. This new conceptualization of mental health treatment emphasizes the importance of community integration, where people are a valued part of the community, not just in the community (Nelson, Walsh-Bowers, & Hall, 1998). The paradigm additionally emphasizes empowerment, where individuals actively participate in and gain control over their lives. Increasing both empowerment and community integration requires a change in the roles of both mental health consumers and professionals. People with mental illness must play the role of citizens rather than patients and professionals must play the role of “resource-collaborator” rather than “expert-technician” (Constantino & Nelson, 1995). This philosophical shift toward autonomy and self-sufficiency in the treatment of mental health problems provides important support for the use of MHSH, which has a rich history of its own.

The oldest MHSH initiatives are Recovery International and GROW. Recovery International was founded by Abraham Low, MD in 1937 as a therapy group that gradually multiplied, became fully consumer-controlled in 1952, and now hosts over 500 self-help groups internationally, along with telephone and online meetings (Recovery International, 2009). GROW is another international network of self-help groups that was founded in 1957 by consumers who developed their own 12-step program based on the Alcoholics Anonymous model. Through the “self-help revolution” (Norcross, 2000), numerous other groups have followed their footsteps, including Schizophrenics Anonymous, National Alliance for Mental Illness, the Depression and Bipolar Support Alliance, and Emotions Anonymous. Although
other types of MHSH are becoming more common, internally focused, minimally structured self-help groups remain the most prevalent from of MHSH (Goldstrom et al., 2006).

The mental health patient’s liberation movement has also played an influential role in the promotion of MHSH. The movement began in the 1970s after deinstitutionalization, when “ex-inmates” who fiercely rejected the professional mental health system began to organize, developing self-help initiatives and advocating for consumer rights (Chamberlin, 1990). The ideology promoted by these groups has increasingly gained mainstream acceptance and their work continues to influence MHSH. Chapters 10 and 12 review some of the advocacy and policy work of MHSH initiatives that continue to promote self-help, consumer rights, empowerment, and a recovery orientation in the mental health system.

Parents of people with mental illness also started self-help groups and in 1979, several groups combined to form NAMI, the national alliance on mental illness, which has groups in over 1000 communities. In addition to organizing self-help groups, NAMI organizes peer-led classes intended to help family members cope with the stress of caring for a family member with mental illness. With over $10,000,000 in contributions in 2007, NAMI is also involved in shaping mental health policy at the state and federal levels, educating the public about mental illness, and fighting stigma (www.nami.org).

Along with the burgeoning interest in MHSH among consumers and family members, elements of the professional mental health system have embraced the use of MHSH and promoted it as a means to achieve recovery (Solomon, 2004). In addition to supporting the use of volunteer-driven MHSH initiatives, the mental health system has also provided funding for the provision of consumer and family run programs. Examples of MHSH initiatives that use funding include consumer-run drop-in centers (Chapter 7), certified peer specialist training programs (Chapter 8 and 9), and consumer technical assistance centers (Chapter 12).

Increased consumer participation in the public mental health system has accompanied the growth in consumer-delivered services. As described in Chapter 10 by Daniel Fisher and Lauren Spiro, consumer voice in the decision-making processes of professional mental health organizations is growing. Additionally, consumers are becoming increasingly involved in the development of their treatment plan (Nelson et al., 2001). Further, professional mental health organizations such as the Veterans Health Administration (2004) are frequently hiring consumers as service providers. Finally, the services of peer support specialists are now Medicaid-reimbursable in a number of states (Sabin & Daniels, 2003).

1.3 Factors Influencing the Use of MHSH

Growth in the power of the consumer movement, as described in the previous section, stands as a critical factor promoting the use of MHSH. However, several other factors are also important to consider. MHSH can provide participants with several benefits at no cost that professional services are less capable of providing. For
example, MHSH may provide friendships, empowering leadership roles, and spiritual inspiration. Participants who obtain these benefits are not only likely to continue participation but may also share their experiences with others who may decide to join. Through word of mouth, many self-help initiatives flourish.

Several factors also impede the use of self-help. The stigma associated with mental illness inhibits participation from individuals who do not want to further identify and affiliate with mental illness (Brown, 2009). Some potential participants also view self-help participation as a sign of weakness, for people who are overly emotional and sensitive. Furthermore, professionals sometimes view self-help with suspicion, unsure of whether participants provide sound advice. Groups that depend entirely on word of mouth may be isolated and liable to falter without external supports such as referrals from mental health professionals. Unresolved internal conflicts may also cause some members to discontinue participation or for the entire initiative to disband (Mohr, 2004).

1.4 Book Overview and Chapter Summaries

This book is organized into six sections. The first section, Frameworks for Research and Practice, has two chapters which review the theoretical foundations of MHSH and a framework for participatory action research with MHSH. The second section reviews three different types of MHSH groups – groups for people with mental health problems, online groups, and groups for caregivers of people with mental health problems. Consumer-delivered services are the topic of the third section, with chapters on consumer-run drop-in centers and certified peer specialists programs. The fourth section focuses on MHSH policy, examining consumer advocacy initiatives and the interface between funding sources and MHSH. Technical assistance is the topic of the fifth section, with one chapter examining US national consumer technical assistance centers and the other chapter describing a statewide collaboration to develop a network of consumer-run organizations. The sixth and final section explores the interface between MHSH initiatives and the professional mental health system, with emphasis placed on the strategic management of partnerships with professionals. The following six subsections provide a more detailed summary of the chapters that fall into each topic.

1.4.1 Frameworks for Research and Practice

Chapter 2, “Theoretical Foundations of Mental Health Self-Help,” reviews the theoretical perspectives commonly applied to mental health self-help (MHSH). Louis Brown and Alicia Lucksted first examine Recovery and community integration, which are multifaceted constructs often used to conceptualize the outcomes of participation in MHSH. Second, the authors present several perspectives on MHSH setting characteristics that influence individual outcomes, including sense of community, behavior setting theory, and empowerment theory. Third, the authors
summarize theoretical perspectives providing insight into how individuals benefit from their interactions with self-help settings, including the helper-therapy principle, experiential knowledge, social comparison theory, and social support theories. Finally, the Role Framework provides a theoretical model that helps to integrate and extend these different perspectives in the literature.

The third chapter, “Participatory Action Research and Evaluation with Mental Health Self-help Groups and Organizations: A Theoretical Framework” poses a series of questions researchers face when collaborating with MHSH. Geoff Nelson and associates address each of these questions by providing a framework for self-helpers, researchers, and others as they develop research projects. Their framework addresses six elements: (a) values, (b) participation and power sharing, (c) social programming, (d) knowledge construction, (e) knowledge utilization, and (f) practice. Embedded throughout the chapter are lessons learned and recommendations for future research and evaluation with MHSH initiatives.

1.4.2 MHSH Groups

Three chapters on MHSH groups examine three different types of groups – groups for people with mental health problems, online groups, and groups for caregivers of people with mental health problems. Authors Nancy Pistrang, Chris Barker, and Keith Humphreys focus on groups for people with mental health problems in Chapter 4, titled, “The contributions of mutual-help groups for mental health problems to psychological well-being: A systematic review.” The chapter first outlines how mutual-help groups fit into the broader picture of mental health self-help initiatives, and discusses some issues involved in conducting effectiveness research on mutual-help groups. The methods and results of the review are then presented. The studies reviewed provide limited but promising evidence that mutual-help groups benefit people with three types of problems: chronic mental illness, depression/anxiety, and bereavement. The strongest findings come from two randomized trials showing that the outcomes of mutual-help groups were equivalent to those of substantially more costly professional interventions.

In Chapter 5, “Online self-help/mutual aid groups in mental health practice,” Jerry Finn and T. Steele review the expanding use of online self-help mutual aid groups. Finn and Steele describe how this form of MHSH provides a number of advantages to consumers since they are not bound to time, place, or social presence. The authors describe research that supports the benefits in areas of health, mental health, addictions, stigmatized identities, trauma and violence recovery, and grief support. Finn and Steele also consider some of the challenges associated with this type of MHSH, including the potential for disinhibited communication, privacy concerns, and misinformation. Future development of online support through social networking sites and virtual communities will become new resources for consumers. In order for online MHSH to be a resource, mental health professionals and others will need to be positioned to help maximize benefits and guard against their potential weaknesses.
Wai-Tong Chien examines mutual support groups for family caregivers in Chapter 6, “An overview of mutual support groups for family caregivers of people with mental health problems: Evidence on process and outcomes.” The chapter summarizes the literature from a systematic search and assesses the evidence on the effectiveness and therapeutic ingredients of mutual support groups for helping family caregivers of people with severe mental health problems. Many studies reported different benefits of group participation such as increasing knowledge about the illness and enhancing coping ability and social support. However, the review points out there is a lack of research examining the long-term effects of mutual support groups on families’ and consumers’ psychosocial health conditions. In addition, Chien discusses lessons learned from development and evaluation on family-led support groups including the major principles in establishing and strengthening a support group, barriers to group development and families who are likely to attend and benefit from group participation.

### 1.4.3 Consumer-Delivered Services

This section reviews two types of consumer-delivered services that typically require external funding – consumer-run drop-in centers and certified peer specialist programs. In Chapter 7, “Consumer-run drop-in centers: Current state and future directions,” Louis Brown, Scott Wituk, and Greg Meissen examine this popular form of MHSH that remains largely volunteer driven. In addition to organizing recreational activities, drop-in centers can host self-help groups, bring in speakers from the community, offer classes to members, organize public awareness campaigns about mental illness, volunteer in the community, and work with professionals, administrators, and lawmakers to improve the public mental health system. Brown, Wituk, and Meissen review research on several different facets of these organizations including their activities, organizational structure, evidence base, funding support, and community relations. Strategies to enhance the organizational effectiveness and peer support of consumer-run drop-in centers are outlined with attention to enhancing empowerment and recovery.

This book also provides two chapters examining the recent emergence of certified peer support specialists at the national and state levels. Chapter 8, “Certified peer specialists in the US behavioral health system: An emerging workforce” by Mark Salzer, describes the development of Certified Peer Specialists (CPSs), who receive specialized training and certification to provide Medicaid-reimbursable peer support and mutual aid. The chapter provides a historical overview and discusses this movement as a significant evolutionary step in the involvement of peers-as-staff in the traditional service system, programs, and workforce. A review of current knowledge about Certified Peer Specialist (CPS) training programs is offered along with research findings on the benefits associated with participating in such training on well-being, knowledge, and employment. Additionally, national findings pertaining to CPS wages, hours worked per week, and number of persons they support, as well as job titles and work activities is presented. Evidence of continuing implementation
barriers, emerging policy, program, and practice issues are discussed, as well as high priority future research topics.

Additional insight into the development and implementation of a statewide CPS program is provided by Emily Grant and her colleagues in Chapter 9. The chapter describes a Certified Peer Specialist (CPS) Program that emerged in Kansas in 2007. Grant and her co-authors trace the roots of the CPS program from Georgia to Kansas with particular focus on the benefits and crucial facets of the programs thought to be linked to program success. In addition, the chapter reports on findings from surveys conducted with over 100 Kansas CPSs. Reported findings include a description of job activities and services, workplace integration, satisfaction, and organizational support. Findings indicate that Kansas CPSs are being received well by many mental health centers, report high job satisfaction, and perceived positive organizational support. Limitations of current research and suggestions for future research are also discussed.

1.4.4 MHSH Policy

This section explores how consumers are shaping mental health policy and how governmental policy can effectively support MHSH. Chapter 10, titled, “Finding and Using Our Voice: How Consumer/Survivor Advocacy is Transforming Mental Health Care,” discusses how consumers are influencing mental health policy. Authors Daniel Fisher and Lauren Spiro describe three components that are critical to the development and sustainability of the consumer/survivor movement and its national advocacy voice, including

- A consensus by the movement that recovery, wellness, and complete community integration are attainable goals for persons labeled with mental illness in contrast to the traditional negative prognosis of maintenance during a lifelong disability.
- Training programs in advocacy designed and carried out by consumer/survivors, such as Finding Our Voice.
- Building the National Coalition of Mental Health Consumer/Survivor Organizations which amplifies the voice of consumer/survivors at the state and federal level.

Their chapter includes a detailed description of these components, providing examples of each, and how they continue to contribute to the future of the consumer/survivor voice.

Chapter 11, “How governments and other funding sources can facilitate self-help research and services” provides a much needed description of the role of government and other funding sources in contributing to and supporting MHSH initiatives. Crystal Blyler, Risa Fox, and Neal Brown provide examples of the types of activities in which governments and other funding sources can engage to facilitate and support self-help research and services. Specific ideas for potential funding of self-help research and service are presented and future directions for self-help
research and services are discussed. Through these examples, the authors point out how the efforts of the federal Community Support Program have contributed to the growth of self-help over the past 30 years.

1.4.5 Technical Assistance

The technical assistance section of the book provides two chapters that examine how technical assistance has been a critical support for MHSH at the state and national levels. Chapter 12, by Susan Rogers, examines consumer and consumer-supporter national technical assistance centers in the United States. These technical assistance centers (TACs) foster self-help/recovery-oriented approaches in the mental health system. The chapter examines TACs’ history, their goals and objectives, the challenges and barriers they face, and their efforts to overcome those challenges and barriers. The chapter includes interviews with leaders of the TACs as well as some of the individuals and group leaders they have served, and with the TACs’ government project officer.

Olivier Dziadkowiec and his colleagues provide Chapter 13, “A statewide collaboration to build the leadership and organizational capacity of consumer-run organizations (CROs).” The chapter begins with the history of the national consumer movement and the history of CROs in Kansas. Following is an in-depth commentary about the collaborative relationship between the Center for Community Support and Research (CCSR) and Kansas CROs. The chapter describes the unique relationship between CCSR and Kansas CROs, partnerships that have developed, and activities to build the leadership and organizational capacity of CROs. Additionally, there is an overview of research studies conducted by CCSR and others to assess the impact and capacity needs of CROs. The chapter concludes with a focus on the future of CROs and the consumer movement in Kansas.

1.4.6 Self-Help/Professional Collaboration

The final section of the book provides two chapters that examine the collaboration between MHSH initiatives and the professional mental health system. In Chapter 14, Deborah Salem, Thomas Reischl, and Katie Randall address the recent trend for mutual-help organizations to form collaborative partnerships with professionally run organizations. Their chapter, “Helping Mutual Help: Managing the Risks of Professional Partnerships” reviews a multi-method case study of a partnership between Schizophrenia Anonymous (SA) and the Mental Health Association of Michigan (MHAM) over a 14-year period. Results are discussed with regard to the lessons learned for managing mutual-help/professional partnerships. The authors draw on organizational theories and risk management principles to discuss strategies by which mutual-help organizations can benefit from partnerships with other types of organizations, while minimizing unintended changes to their basic beliefs, processes, and structures.
The fifteenth and final chapter, by Thomas Powell and Brian Perron, calls attention to the immense amount of support and services provided by MHSH. Their chapter, “The contribution of self-help groups to the mental health/substance use services system,” contends that many MHSH initiatives are largely misunderstood by professionals and not coordinated with professional services. Their chapter reviews previous epidemiological surveys that have documented the profiles of self-help users, the amount of self-help use, and the association between self-help use and professional services. The chapter also discusses the organizational supports necessary for effective collaboration between self-help groups and professional services. While the boundaries between mental health services and self-help groups must be respected, both parties have much to gain by entering into more extensive community partnerships.

1.5 Future Research Directions in MHSH

A key research question facing MHSH is to understand the extent to which MHSH is helpful and the conditions under which it succeeds. These effectiveness questions are best answered with randomized controlled trials (RCTs). However, RCTs are difficult to execute effectively in MHSH settings because MHSH initiatives are highly dependent upon self-selection. As consumer and family-driven initiatives, researchers and professionals cannot control their use, which makes the use of random assignment difficult.

One strategy that may make random assignment more feasible in a practice context is to use an intensive engagement intervention when assigning individuals to the treatment condition. A simple referral is frequently too weak of an engagement intervention because people often do not comply with the recommendation. However, previous research has found the use of a sponsor outreach intervention to be an effective strategy for increasing the likelihood that referral will lead to attendance (Powell, Hill, Warner, Yeaton, & Silk, 2000; Sisson & Mallams, 1981). Another strategy for enhancing engagement may be to supplement any in-person or phone contacts from professionals and group members with mailings and emails. Evaluations that use these engagement techniques can serve as both excellent outcome evaluations and tests of the effectiveness of different outreach tactics. Research that provides insight into the engagement process is of great practical value because the most prominent needs of self-help groups center on member involvement, attendance, and recruitment (Meissen, Gleason, & Embree, 1991).

Numerous other research strategies are equally promising. For example, longitudinal observational field studies can study the trajectories of different people who encounter MHSH initiatives. Findings can provide insight into patterns of engagement and disengagement. If enough groups are included in these studies, they will be able to examine how group differences influence participation, outcomes, and sustainability. Such studies can aid the development of guidelines for ideal group characteristics that promote participation, group sustainability, and individual benefit.
Qualitative research also has the potential to make important contributions to our understanding of MHSH. For example, in-depth interviews and focus groups can provide important insight into the creation of useful self-help group philosophies and effective outreach materials. Interviews with self-help leaders and professionals who support self-help groups can help build understanding of how professionals can best interact with and support MHSH. Given the lack of theoretical guidance in approaching these topics, they are ripe for development through qualitative techniques.

1.6 Future Directions for MHSH Practice

The influence of MHSH is likely to continue expanding in the foreseeable future, and could lead to dramatic changes in the mental health system. The use of consumers as providers of mental health services is a radical departure from the traditional mental health system. If they prove to be similarly effective in providing services as mental health professionals, service providers who do not hire consumers risk facing legitimate charges of discrimination.

Another area of potentially tremendous growth in MHSH is the use of online self-help mutual aid groups. These groups lack participation barriers such as transportation and scheduling, which makes participation substantially easier for a large portion of the population.

Regardless of how paid and online peer support develops, currently existing volunteer-driven MHSH groups are likely to persist because the people who create them continue to need them.

1.7 Conclusion

This 15-chapter edited volume organizes and synthesizes the current knowledge base on MHSH. Consideration of the issues addressed can help to enhance MHSH effectiveness. Although many questions about the development of effective MHSH initiatives remain, the tides of opinion are turning in favor of MHSH as a low-cost supplement to professional mental health care. Rigorous experimental evaluations indicate MHSH can be effective. Future research needs to identity the conditions under which MHSH initiatives both thrive and fail. Such knowledge can support a diffusion of effective MHSH initiatives that promote the well-being of mental health consumers and their family members. However, MHSH implementation will always remain an art that science can only help to refine.

References