



CALIFORNIA NETWORK OF MENTAL HEALTH CLIENTS

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The State of Self Help in California: Client Perspectives

A Report of the California Network of Mental Health Clients

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March, 2008*

About the California Network

Founded in 1983, the California Network of Mental Health Clients (CNMHC) is the nation's oldest statewide client advocacy group. Over the last twenty-five years the Network has become an integral part of the statewide advocacy system for mental health clients and is today a full partner in all aspects of mental health policy and planning.

The objectives of the California Network of Mental Health Clients are:

- To empower clients of the mental health system through self help groups and networking statewide.
- To confront discriminatory attitudes about mental health clients in the public, the media, the mental health system, and within mental health clients themselves.
- To provide a strong voice by and for mental health clients; to be heard on all issues concerning clients and public policies affecting them in government, the media, and the community.
- To promote and instill the rights of clients in and out of treatment situations, with special attention to the right to freedom of choice.

About the Office of Self Help

The mission of the Office of Self Help is to instill self help and consumer-run services and self help principles as a core component of California's mental health system, and thus facilitate a recovery-based vision and individual recovery.

Activities of the Office of Self Help include:

1. Assessing the status of self help groups and programs and self help principles as they currently exist throughout the state

2. Fostering self help services and groups throughout the state by providing technical assistance and support
3. Providing educational and training opportunities on self help programs and principles for mental health, and mental health-related communities.

About the Project Staff

Dave Hosseini has served as Interim Director of the Office of Self Help since October 2007. He began his career in 1984 as coordinator of a mental health drop-in center. He later served as Program Director of three drop-in centers, and Executive Director of Consumer Self Help Centers and the Office of Patient Rights in Sacramento for nine years. He was also Public Policy Advocate for the California Association of Social Rehabilitation Agencies for two years. Currently he looks forward to returning to retirement and perhaps helping with other mental health-related projects in the future.

INTRODUCTION

The purpose of this project is to determine the state of self help and self help activities in California. While not a scientific study, this report is a snapshot of the opinions, hopes, dreams, and concerns of representatives of the consumer community in five of the regions that make up the state. Focus groups were assembled at a variety of locations and programs, including a traditional day treatment program, three semi-independent consumer-run programs and a completely consumer-run nonprofit organizations. Locations for the focus groups included Redding (Far North), Santa Rosa (Bay Area), Sacramento (Central Valley), City of Commerce (South) and San Diego (Far South). Additional comments were solicited at a shorter focus group held in Berkeley, through the CNMHC list serve, informal conversations, and at a formal session at the annual client forum of the CNMHC.

Focus group participants often requested (and were assured) that their names and locations would be confidential. This assurance enhanced the fluidity and scope of the discussions. It is important to note that this paper does not represent the opinions of all consumers, or even the opinions of all consumers in a particular region. These opinions are, however, representative of individuals for whom self help and the self help philosophy have become important foundations of the recovery journey.

A discussion of almost any part of the mental health recovery movement must begin with the acknowledgement that just as the movement itself is in relative infancy and still evolving, the language we use to describe the activities of the movement are also still in flux. Just a few decades ago, there was no language used to describe the activities and ideas of recovery. The whole notion of recovery, the idea that persons with mental illness could recover, was not accepted or considered realistic. The principle that persons who have experienced illness can and should have a role in their own treatment, and the principle that they can and should have roles as helpers, advocates, managers, and designers of the system are revolutionary new concepts for which descriptive language has not yet been agreed upon.

The fact that self help, too, is still a new and evolving practice presented a major challenge for this report. In order to ascertain the state of self help, agreement about a set of defining principles was necessary.

The early leaders of the mental health recovery movement, many of whom are still active in California and throughout the nation, faced a challenge in trying to define just what was meant by self help. Because the self help philosophy was developed at least in part as a reaction to a system which was experienced as too confining, proscribed, and limited by excessive labeling and categorization of individuals, many in the self help movement protested attempts to overly categorize self help. While the resistance of some to analysis of the self help philosophy was strong, a major step in finding language to describe it was taken in 1983, with the publication of the seminal self help guide, *Reaching Across*.

Reaching Across, consisting of articles written by early leaders of the self help movement, is not only a guide to the philosophy, but is also a primer on the establishment of client-run services. The following excerpt recounts how the late Carol Henne, an early California client leader, went about organizing a self help program. The simplicity of design is typical of many early self help programs. *Reaching Across* explains,

Carol made up a flier advertising the new support group, stating clearly ‘no professionals please’ and ‘this is not a therapy group.’ The expertise for the layout and lettering of the flyer was donated by a friend. Carol made 200 copies and distributed them to 90 different mental health professionals, asking them to please post for their clients to see. She also posted them in all mental health clinics, in public libraries, and bulletin boards--all places where clients go.

The first meeting was held on the lawn of the local mental health social center. People who came to the meeting were a different crowd that came to the day center. Not many people came to the first meeting, in fact it took about four months for membership to grow. Later Carol asked for and received a small grant from a local church which was used to fund social and recreational activities...the support group has not felt the need for a name. It is simply the self help group for past and present mental health clients.

Today, self help programs have multiple sites, scores of consumer staff, and budgets far exceeding the small church grant secured by Carol. Through all these changes, the programs have struggled to remain true to the original vision, which values a holistic sense of personhood, and the healing power of sharing the client experience.

Another value and practice that has remained strong since the early days is the concept of membership. It is no accident that participants at most self help programs throughout the state refer to each other as “members.” The value of membership and the sense of self worth that come from belonging have a special resonance for any group of people who, through no fault of their own, have found themselves tossed to the sidelines of mainstream life. Those whose lives have been touched by mental health issues often share a strong, almost familial tie with each other. Though the experiences of each person are unique, the dual impacts of stigma and a system historically characterized by harsh treatment create strong bonds and enhance a common spirit of unity and struggle.

Today, as the impact of a system that describes itself as “recovery-based” takes hold, and as memories of the punitive system of thirty years ago fade (or are nonexistent for younger people), it is significant that among all the terms and concepts upon which consumers sometimes disagree, the concept of membership, especially in the voluntary day centers, is still as strong as it was when people met on back steps, in rented rooms, and on lawns as they began what we today know as the self help movement.

The Daytime Drop-In Center and Self Help

Although the self help philosophy can be expressed in places ranging from parks to coffee shops, the primary venues of self help programs are voluntary daytime drop-in centers. Since most of the information gathered for this report came from focus groups conducted at voluntary daytime drop-in centers, the following brief background and review of the types of centers may be helpful to the reader.

The voluntary daytime drop-in center can provide simultaneous services to consumers on a number of levels. Homeless individuals and those new to the system use the centers as an entry point. Some individuals use the centers as a source of contact which provides an ongoing sense of community. Some take advantage of employment and volunteer activities available at the centers, using these experiences as a springboard to full- or part-time employment in the mental health system and beyond, while others use the centers as a form of respite or reentry to the system, attending only at times of great stress or need.

As mentioned above, the programs visited for this report ranged from a modified traditional day treatment program with strong elements of self help to another, which has been completely client-run for over two decades. All of these programs, when adequately funded and developed, can offer a myriad of services that make them full-service community centers, providing not only a basis of self help, but also practical support for basic needs, including meals, emergency food, clothing banks, transportation vouchers, benefits education and advocacy, and laundry facilities, in addition to providing socialization and a sense of community.

Along with these provisions, voluntary daytime drop-in centers offer peer support and empathy, which are recognized as powerful building blocks to recovery and wellness; the centers which are strongest in providing empathy and role modeling are those with a high degree of consumer involvement and control.

In general, there are three categories of drop-in programs. The first tier and most emphatically powerful kind of daytime drop-in center is operated by nonprofit agencies that are completely consumer-run and managed. At these centers, participants see other consumers engaged in all the aspects of the running of a business and a social service agency, and the message that recovery is real strongly reverberates throughout the program. A second type of drop-in center is the type which functions as a semi-independent consumer-run entity, but which may have some contractual relationship with a larger nonprofit or county. This model also communicates strongly the idea that individuals can and do recover, especially when the organization is given a

high degree of autonomy and respect within the larger umbrella organization. Along with these two most desirable models, other models of the daytime drop-in center exist, ranging from a blended non-client/client staff base, to centers that have only token consumer involvement. While parts of the self help philosophy can be adopted in almost any setting, the most powerful is undoubtedly the client-run organization.

Methodology

Focus group sites in the five regions were selected after consultation with leaders in the regions. Each site promoted the focus groups with flyers sent by the Office of Self Help several weeks in advance of the date, and members of each group received a light lunch as a thank you for their time and effort. The five main groups were about two hours in length. Approximately 134 people participated in the focus groups, including those who attended the Annual Client Forum and the smaller Berkeley group. Comments were recorded on poster paper, and at most groups a participant from the local program was hired to assist in recording comments. In addition, an optional self-reporting statistical form was distributed at all the groups except the abbreviated group at the client forum. Additional comments were received through the CNMHC list serve and personal contacts.

Seventy-three persons responded on the written questionnaire distributed in the five main groups.

Partial Statistical Breakdown

Gender	Age	Racial/Ethnic Identity	Sexual Identity	Physically Challenged
Men: 36	Range: 22-68	African American: 9	GLBTQ: 7	P C: 3
Women: 37	Average: 45	Latino: 8		
		Asian: 8		
		Non-Latino White: ≈48		

Rating of Common Services

The written questionnaire presented the following list of services that may be found at self help drop-in centers: self help groups, informal drop-in, in-house social and recreational activities, advocacy and referral, in-house vocational opportunities, meals and food support, and out-of-house recreational opportunities. People were asked to choose which services were most important, and while not all responded to this request, the rankings follow:

- 1) Self Help Groups
- 2) Meals and Food Support
- 3) Advocacy and Referral Services
- 4) In-House Vocational (opportunities to earn money)
- 5) Informal Drop-In

- 6) Out-of-House Recreational Activities
- 7) In-House Recreational Activities

The focus groups consisted of dialogues which began with of a broad review of the characteristics of self help as described in *Reaching Across*. The review was followed by discussion of the following questions:

- A. Does what has been listed meet your idea of what self help is?
- B. What does self help mean to you?
- C. How and why is your participation in a self help program important to you?
- D. How is participation in a self help program different than participating in other types of programs?
- E. Are there other values or ideas that you think should be a part of the self help philosophy?
- F. [What are your] overall recommendations for the future?

Part 1: Definitions and Characteristics of Self Help

This section of the paper is divided into two parts. The first part discusses the participants' responses to the question, "What is self help?" It is covered in greater detail than the other questions because it provides the foundation for participant responses as a whole. The second part deals directly with participants' responses to the other questions.

What is Self Help?

A first task in beginning to formulate this paper was an attempt to define self help and the self help philosophy. In order to determine "the state of self help" we needed to define what a self help group is or is not right now, in the year 2008. As a beginning point, the description below from *Reaching Across* was referenced.

Definition of a Self Help Group (from *Reaching Across*)

A self help group is a self-defined group of mental health clients that decides its own goals and methods of making all major decisions.

Characteristics of Self Help Groups

- Self defining own needs
- Equal power of all members
- Being respected as people, not as clinical diagnoses
- Totally voluntary, non-coercive
- Independent of mental health system
- Responsive to special populations, such as bilingual, disadvantaged, physically disabled, people of color, GLBTQ, etc.

Participants in each focus group, those who responded online, and those who responded in informal conversations were asked to evaluate the above characteristics with respect to whether or not they believed that the ideas were currently an accurate representation of the core values of the self help philosophy. There was overall agreement that the above characteristics provided an important description of self help. Agreement was pronounced among those with more experience in the self help and client movements. These individuals also believed that the core principles are in danger of being compromised, perhaps beyond recognition. There was a feeling among veteran leaders and others that as self help services have become more a part of the mental health system, they are in danger of reflecting the system rather than providing alternatives.

Specific concerns were mentioned in the following areas:

Self Defining Own Needs: Repeatedly cited as adverse were what some perceived as a growing list of requirements thrust upon programs as they receive more funding from the traditional mental health system and other granting sources. Specifically mentioned as problematic were expectations that the programs serve as gatekeepers in determining who is and who is not eligible to attend; other statistical exercises that, to some, feel too much like labeling; and staffing patterns that included professionals and non-clients. In one instance, one program sought to name its center after a specific deceased individual who many saw as a client leader worthy of such an honor--these wishes were vetoed by the county in question.

Equal Power of All Members: For many programs, the days of members sitting on a back porch deciding on policy and program issues are long gone. The advent of larger, more complex budgets has brought the addition of accountants, non-client consultants, and non-client employees. In one group it was mentioned that some client employees have come to resemble non-client staff of traditional programs more than the rank and file of client membership. Income disparity between client staff and the membership is widening in many places around the state. It was agreed that consumer staff deserve decent rates of pay and the lack of parity between rates of pay of consumer staff and other mental health staff was seen as an important issue that must be addressed. The reality however, which was expressed in many ways throughout the focus groups, is that income disparity and the stark differences in lifestyle between even moderately satisfactory incomes of some client workers and the extremely low government subsidies that most clients live on does impact the self help environment. Despite a general adherence to the stated principle of equal power of all members, many have come to feel that once “you have the keys,” the original concept of equal power of all members is no longer entirely accurate. At one focus group a participant called for open staff meetings, saying that seeing staff meet behind closed doors, even if they were consumer staff, made that person feel less than and second class.

Client leaders and others recognized the need for adhering to standard business practices, but some also lamented the fact the true “bottom up” grassroots participation seemed to be diminished. Some programs, recognizing that the core value of equality among all members has been compromised, sought to put strategies in place to insert grassroots ideology into the modern milieu.

Respect as people, not as a clinical diagnosis: This value was appreciated and rated as important by many of the persons responding to discussion points. However, long-time client leaders and others expressed concern that statistical reporting requirements are bringing some self help programs dangerously close to relying on diagnosis and labeling.

Independent of mental health system: Most individuals held the view that self help programs are no longer independent of the mental health system. A general theme emerged, which seemed to be that while philosophical ideals and practices may strive to be independent of the system, the stark reality of the sources of most funding clearly ties self help programs to the system in basic and unavoidable terms. Some individuals remarked that this co-opting by the system diminished the overall efficacy of the concept of self help, but others did not agree that independence from the system was desirable or was a characteristic that brought strength to the philosophy. For some, it was important that self help programs be an integral part of mental health systems, and that the values embodied in self help be seen as a core part of the system, rather than a distinct alternative.

Responsiveness to special populations, bilingual, disadvantaged, physically disabled, people of color, GLBTQ: Participants generally agreed that more effort needs to be focused on reaching out to special populations. Programs have made admirable efforts to include a variety of languages in at least some portion of services provided, but some felt that the budgets provided for the programs did not permit the depth of language fluency required by programs regions of diverse populations. While there was a desire to do better in all areas of responsiveness, two particular areas were mentioned more frequently than others. The first dealt with a lack of concurrent services for children of self help program participants, especially very young children not yet attending school. The lack of child care opportunities, either at the self help programs or nearby, was cited as a reason parents were unable to attend the program. One person stated that she saw her inability to attend regularly as particularly sad, because as a young mother experiencing the struggles of being a parent of a small child, she could especially benefit from the extra support the program could provide.

The second most frequently mentioned area for improvement in responsiveness dealt with a lack of comfort level felt by gay, lesbian, transgender, bisexual and questioning individuals. At several points during more informal conversations that took place in preparation for this paper, multiple people reported that they did not feel comfortable to express or even refer to their sexuality within the context of their local self help program. This level of reluctance to be open about sexual preference extended to at least two staff members of programs who said that they did not feel comfortable revealing their sexuality, even in the most casual way, to program participants. One person said that he felt there was an overwhelming amount of casual use of derogatory terms and other homophobic content on a daily basis at his worksite. In addition, he did not feel fully supported by other staff or management in combating such comments.

Part II: Direct Comments and Analyses

Below are participants' comments in response to the other questions asked in focus groups, online, and in informal conversations. The comments are followed by an analysis of some salient points and commonalities.

What Does Self Help Mean To You?

Direct Comments (some participant responses are listed below):

- Groups that are friendly
- A safe place to share
- Help in preventing relapse
- Help to find resources
- Opportunities for friendship
- A safe haven
- A place to have opportunities--where we have opportunities, we rise
- Healing power of being a positive role model for others
- A support system that is like a family unit
- An encouraging environment
- Opportunity to be independent
- I can choose to come or not to come--I am respected
- At the vanguard of system transformation
- Not a case, a person
- A place to learn to see yourself in a different light
- Fellowship
- A vehicle for healing
- A chance to work
- Causes me to have respect for others and respect for myself
- Enhances choice
- I am not alone
- A break from my life in my board and care
- Here I am someone
- I am free to progress (or not)
- A giving circle
- Something real in my life, something that is mine

Analysis: Those who commented in the groups were unanimous in their appreciation of self help services and the role that self help has played in contributing to recovery. Others mentioned an overall atmosphere that felt friendly, non-institutional, and safe. There was a general appreciation for the fact that even though some of the programs were housed in clinical buildings, staff and members of the current programs took great care to make the programs feel friendly. One person commented that she liked the fact that her self help program felt like a home rather than an office. She mentioned that comfortable furniture and member-created art on the walls, along with photos of center-related events and activities, were especially comforting to

her. Also mentioned repeatedly was the idea that self help programs offered multiple levels of opportunity and responsibility. People voiced appreciation for the value of giving back, whether it was a simple task like putting out the morning pastries or a more complex paid position within the organization. The voluntary nature of the programs was repeatedly mentioned as being of great value and importance. Several people in the groups felt that the emphasis on choice (i.e. whether to come or not, how long to stay, what activities to participate in) translated to them as a form of respect, which honored their sense of wholeness.

How and why is participation in self help important to you?

Direct Comments:

- Learn new things
- I wake up to the world
- Gives me purpose in life
- I feel like I belong somewhere
- Shows me I am not alone
- I am respected here
- I see others doing better [and] it gives me hope; [I] see others struggling, [and] it reminds me of how far I have come
- Helps me feel like a part of things again
- It's like family
- I never really felt valued before starting in this program
- I feel a part of a real community
- It's such an alternative to what I experienced in mental health before
- Knowing the staff are clients, like me in lots of ways, just makes it better, somehow more meaningful
- I get real help--things like meals, help with food, a chance to do recreational activities I could not or would not do on my own
- It takes me out of my shell

Analysis: Participants were enthusiastic about the place that self help programs held in their lives and in their recovery. Self help was seen as a way to join (or rejoin) a place of community, and because of the emphasis most programs place on choice, the philosophy also was also seen as a way of regaining lost power. The programs were seen as an important antidote to the isolation that often accompanies symptoms, and as a remedy to quality of life issues (i.e. poverty) that can sometimes be a result of symptoms.

What are the differences between self help and other programs?

Direct Comments:

- Here I am not a billing number
- Do not need to fear the police or 5150--once that has happened to you, it never really leaves you, but here at least the fear is less

- More compassion and respect because staff have been there
- My own unique experience is honored rather than seen as a problem
- Program shows interest in basic needs rather than just symptoms
- Non diagnosis-based
- Clinics tell me “you can’t do it,” [and] self help tells me “you can”
- Not just a passive recipient here but also an active member
- Other programs talk at you--here people talk with you
- Other programs have overemphasis on security buzzers [and] bulletproof windows, [which] make me feel "less than"
- More understanding, empathy
- Here there is practical stuff, like laundry facilities, meals, and showers for those who have none
- People look at me differently here--they see me
- Less anger, attitude from staff
- Staff explains rather than talks down
- Opportunity to contribute at all levels
- Help one another rather than being passive recipient
- Staff is open to feedback

Analysis: While the idea of self help may have had different meanings for different individuals, participants were firm and clear in being able to delineate the difference between self help programs and other programs without an emphasis on self help. Because almost all programs were client-run (at least at the direct service level), people felt a genuineness that they did not feel in other programs. The lack of billing codes, involved and intrusive intake procedures, and the non-diagnosis-based core of each program were all described as significant and favorable differences. In addition, program members appreciated the fact that large parts of each program centered on strategies to get through real life dilemmas rather than strictly clinical issues (i.e. how and where can I find housing, a job, the most reasonable food market). Also mentioned frequently as a strength of self help programs was the fact that many of the programs offered in-house experiences to help with real life issues, such as opportunities to earn income through stipend positions (and regular employment), help with transportation issues, and indirect income assistance through the availability of meals and other types of direct nutritional assistance. Staff empathy was also seen to be at a different level, due largely to the fact that most persons in staff positions were willing to talk openly about their own mental health histories.

Are there other values, ideas, or services that you think should be a part of the self help philosophy?

Direct Comments:

- Increased emphasis on housing
- More involvement with family members for reconciliation, education
- More involvement with board and cares
- Better and more outreach
- I did not hear of this program for three years

- More involvement in crisis care alternatives
- Housing, housing, housing!
- It does not seem that self help programs are valued by the system as much as other programs--look at budgets, salaries, buildings, etc.--real life experience should be valued

Analysis: Although not directly related to self help, concern about housing issues was a hot topic throughout many sections of the focus groups. Members expressed a desire to see the values and philosophy of self help extended into the housing arena through client-run housing programs, voluntary housing cooperatives, and paths to and information about home ownership. Also mentioned was dissatisfaction with the current board and care system, both from the perspective of current residents and that of others in self help centers who interact with current residents and witness their struggles. Several members also felt that consumer-run crisis alternatives based on the self help model would be a viable preventative measure and alternative to hospitalization. Also expressed was a perception that though existing self help groups are funded by the system, they still have not achieved a parity of value to other services. Members cited overall budgetary concerns, including differences in salary between consumer staff and non-consumer staff as an illustration of what many felt was a “second tier” role of self help centers in the system.

What are your overall recommendations for the future?

Direct Comments:

- Move toward true client control rather than funder control
- More outreach to community in the area of stigma reduction /education
- Consumer-run programs can go only so far on second rate budgets
- Increased nutrition education and assistance
- More help with criminal justice issues
- Become more active in medication issues
- Wrap plan for vocational issues
- Besides emphasis on hiring clients into the mental health system, have additional focus on other jobs--everything from professional, to fast food, to cashiering, etc.

Analysis: As stated previously, several respondents had concerns that the integrity of the original idea of self help is being challenged by increasingly stringent funding requirements. Additional concerns were raised about inadequate budgets relative to the services provided, especially when compared to budgets of other, more traditional programs. On the programmatic side, members in multiple locations expressed a desire for increased assistance related to nutrition issues in light of high rates of diabetes and obesity in many client groups. Others hoped that self help programs could better educate themselves, especially in relation to educating others about medication alternatives and about medication safety concerns. Vocational issues were also highlighted. Several people hoped that self help programs could become more involved in directly helping those with criminal justice issues, especially with regard to expunging criminal records for employment purposes. In addition, some consumers wished to see a broader array of vocational services and planning available, beyond job planning geared toward entry into human services employment.

CONCLUSION

Those who contributed to this paper place a high value on self help and the daytime drop-in center, a chief method by which the self help philosophy has been expressed. At the same time, clients are far from comfortable about the future of self help in our state. Problems ranging from increased reporting requirements to a lack of dedicated resources for addressing self help issues are causing concern about the long- and short-term viability of a true client-run self help philosophy. The establishment of a new type of program, the Wellness and Recovery Center (supported largely by funding from the Mental Health Services Act), has in some ways added to rather than diminished anxiety about the future of self help. Like so many terms in our evolving system, just what constitutes a Wellness and Recovery Center program is largely undefined. The quality of these programs, especially the degree to which consumers have been involved in their planning and ongoing operation, varies so greatly that the term “wellness and recovery center” has little meaning in the context of a statewide discussion of self help.

As was stated in an earlier section of this report, the self help philosophy was developed at least in part as a reaction to a mental health system that was largely experienced as unresponsive to real needs, disrespectful of personal rights, and devoid of principles that support hope and recovery. Today, thirty years after the beginnings of self help, the system seems to be transforming in a constructive and affirming way, and the desire for genuine consumer-run alternatives remains strong. Conversations with consumers around the state clearly point to the idea that *involvement in the system and system change should not be mistaken for a surrender of the important ideals and characteristics that make up self help*. In addition, the challenges facing self help are by no means all external. Client groups are struggling, with varying degrees of success, to maintain grassroots leadership models. Rather than adopting uncompromising and narrow business models, client groups aim to accomplish goals and program requirements while still reflecting the self help philosophy.

Another problem confronting the integrity of self help groups is the professionalization of jobs within self help organizations. This creeping professionalization comes at the expense of the hiring of consumers, many of whom may have the empathy and people skills needed to be self helpers, but may lack academic backgrounds and such skills as computer literacy. Consumers without these auxiliary skills often find themselves in permanent part-time jobs or internships with little hope of advancement. Failure to address this issue threatens to create two classes of consumers, those who hold jobs with professional trappings, and those who are, by virtue of economic deprivation and other factors, relegated to a kind of permanent underclass within an underclass. At the same time, consumers holding jobs in self help organizations and other parts of the mental health system are often confronted by the fact that their salaries and job security are not equal to those of non-consumers.

Yet, for all the challenges it faces, self help is clearly a philosophy and approach that is valued by both consumers and funding groups.¹ In order to maintain and increase the progress that has

¹ The CNMHC Office of Self Help will continue to serve as a clearinghouse and information source for existing and developing self help programs. Specifically, in response to this paper's findings, OSH will seek to develop training and advisory materials addressing issues of participatory leadership and full client inclusion at all levels, including

been made in implementing self-help programs, the continued education of both consumers and providers concerning the values and ethics of self-help programs must have a high priority throughout the state. In addition, in order to maintain the integrity of the self-help concept, funders should resist the temptation to mold the programs into mere extensions of traditional programs, and should instead work with, listen to and value the collective wisdom of self help

strategies for promotion of child care opportunities and eradication of perceived bias toward the GLBTQ communities.