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Something is Happening: The Contemporary Consumer and Psychiatric Survivor Movement in Historical Context

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Abstract

Despite three major reform movements over the last 300 years, the mental health system has been remarkably resistant to change. Today, another period of reform is underway, only this time, new players - dissatisfied ex-psychiatric patients - are organising to affect the process of change. This paper discusses characteristics of previous movements and examines their similarity to and difference from the present consumer and psychiatric survivor movement. It appears that the new participants have shaped the rhetoric of reform but it remains to be seen if they can affect the reality.

Introduction

In Canada, the mental health system is undergoing yet another period of reform. This time, however, the process of change will be affected by a movement of dissatisfied ex-psychiatric patients that has formed in this country and in the United States, as well as other parts of the world. Some members of this movement call themselves consumers. Others call themselves psychiatric survivors because they contend that psychiatric treatment is not only unhelpful, but 'inhumane, hurtful, degrading and judgemental" (Unzicker, 1989,p.71).

This paper explores three preceding periods of mental health reform: the 19th century asylum movement, the early 20th century mental hygiene movement, and the deinstitutionalisation movement of the 1960s and 1970s. I will then discuss a fourth and contemporary drive for change, the consumer and psychiatric survivor movement, which has emerged in the past decade and which appears to be different from its three

predecessors. Finally, I will attempt to ascertain whether or not this present-day movement's goals mesh with the basic elements of mental health reform as recently announced in an Ontario policy document called Putting People First.

Social Movements

Social movements are thought to be one of the primary agents of social change (Wilson. 1973). Goldberg (1991) offers a useful definition: "a social movement is a formally organised group that acts consciously and with some continuity to promote or resist change through collective action" (p. 2). Heberle (cited in Wilkinson. 1971) notes that social movements must also be integrated by "constitutive ideas or ideologies" (p. 22), and Wilkinson (1971) adds that there must be active participation of some sort on the part of a membership. Further Oberschall (1973) states that in order for social movements to form, there must be an "us" who are badly off and a "them" who are thought to have caused our troubles. A final point, also contributed by Oberschall, is that movements must have leaders who can rally the members nd focus their efforts.

Mauss (1975) proposes that movements pass through a number of stages. He calls the first stage incipiency, where members grope for coherence and control. The second stage is that of coalescence, which marks the beginning of some sort of formal organisation. The third stage is institutionalisation. At this point, the government (usually the target of protest) has been forced to develop a number of coping strategies in order to deal with the movement; some may entail its eradication, others may involve its incorporation. If a movement has achieved some form of success, it enters the fourth stage, fragmentation. Radical leaders who are not absorbed into respectability pull away and any further protest activities will have little effect because the movement is, by now, well into the fifth stage, demise.

The above ideas obviously do not represent an exhaustive review of the social movement literature. Nevertheless, they provide a sufficient frame- work from which to

examine the first three movements which sought to reform mental health care in Western societies: asylum, mental hygiene, and deinstitutionalization.

The Asylum Movement

The asylum movement had its beginnings in Europe at the turn of the 19th century. In England, Samuel Tuke took up the cause of a fellow Quaker who had died while incarcerated in a madhouse (Scull, 1979). Although a specific account of this particular victim's experiences is not available, descriptions from his contemporaries have survived:

“At Bethlem (Bedlam), violent madwomen were chained by the ankles to the walls of a long gallery; their only garment a homespun dress. At another hospital in Bethnal Green, a woman subject to violent seizures was placed in a pigsty, feet and fists bound; when the crisis had passed, she was tied to her bed covered only in a blanket.” (Foucault, 1965, p. 71)

As an alternative to such "treatments," Tuke established the York Retreat, where he developed new theories for the cure of madness which became known as moral treatment. He believed that if he welcomed the insane into a family-like environment, treated them to nourishing food and invited them to partake of soothing pursuits, they would be cured (Scull, 1979). The York Retreat thus came to be called an asylum, or place of sanctuary where people, once removed from the poisonous effects of the world and appropriately guided, could return spontaneously to health (Deutsch, 1949).

The York Retreat is only one example of the types of changes that were taking place all over Europe. In the United States, Dorothea Dix, a school teacher from Massachusetts, took up the cause and embarked upon a forty-year campaign to establish asylums in the United States, Canada and England (Tiffany, 1891). Her success was phenomenal. She and her followers (upper-class philanthropists) can be credited with the establishment of hundreds of asylums housing thousands of people (Hurd, 1917).

Over time, however, ideas regarding economy of scale took over and altered the vision of asylums as small, architecturally superior homes located in the restorative countryside. Instead, they were usually built so as to constitute the largest building within the province, state or shire. Additionally, the newly invented mechanical systems which were designed to service these huge buildings began to fail, creating unspeakable conditions (Brown, 1980). Worst of all, the asylum staff were often unskilled and sometimes brutish and cruel. By the mid-19th century Dorothea Dix's enormous creations had deteriorated to the point where they resembled the overcrowded and unhealthy prisons that had sparked her movement in the first place (Rothman, 1970).

The Mental Hygiene Movement

The mental' hygiene movement had its beginnings at the turn of the 20th century. Clifford Beers, a well-to-do, Yale educated young man suddenly went mad. When he was finally released from a series of asylums, he wrote a book about the abuses he had suffered entitled A Mind that Found Itself (Beers, 1917).
“First I was knocked down. Then for several minutes I was kicked around the room - struck, kneed and choked. . . my shins, elbows, and back were cut by his heavy shoes. I was severely cut and bruised. When my strength was nearly gone, I feigned unconsciousness. This ruse alone saved me from further punishment, for no premeditated assault is ever ended until the patient is mute and helpless.” (p. 163)

“The doctor inserted between my teeth a large wooden peg. He then forced down my throat a rubber tube. Then the attendant adjusted the funnel, and the medicine, or rather liquid - for its medicinal properties were without effect upon me - was poured in.” (p. 140)

Over the next 25 years, he told and re-told his story in the service of the mental hygiene movement whose members believed that insanity was an illness which could be prevented by clean living, defined as the promotion of a well-trained mind, devoid of

impure thoughts. The movement's important additional goals were to enhance the status of the "mentally ill," alter public attitudes, and improve conditions in asylums (Dain, 1980).

Beers, however, was "was not by nature a critic of society and its ills" (Dain, 1980, p. 326). Neither he nor his followers questioned the value of psychiatric treatment or incarceration and instead argued that asylums were violent, cruel, and neglectful places only because there were too few properly trained psychiatrists and other professionals among the staff (Dain, 1980). In fact, the mental hygiene movement, aided by the prominent role psychiatrists played in World War 11, helped legitimise the value of psychiatric intervention in all sorts of human problems previously thought of as "just life" (Grob, 1991).

In the end, the movement was unable to achieve its stated goals. It was true that people now had a new, and some would say, more respectful language with which to discuss the insane (the mentally ill), but people's attitudes toward them remained much the same. Additionally, the movement's focus on early detection and treatment as prevention measures had the unintended effect of promoting institutionalisation among the middle classes who heretofore had escaped the psychiatric gaze. Thus, mental hospitals, which traditionally had served mostly the troublesome poor, began to welcome a new class of patient and, as a result, became even more crowded than before (Carrol, 1964). Most discouraging of all, complaints of abuses within asylums had multiplied, indicating that conditions had actually worsened over the life of the movement (Dain, 1980).

The Deinstitutionalisation Movement

The third reform movement in mental health began, as with so many others, during the turbulent 1960s. Unlike the first two movements, it did not have a charismatic leader but in the United States, the Kennedy administration paved the way for the creation of a community mental health network outside mental hospitals (Heseltine, 1983). It

appears that the administration was responding to pressure from four sources. First, the civil rights movement had a far-reaching impact and the rights of everyone were now open to scrutiny. Second, a wide variety of professionals, in addition to doctors, had become interested in careers within asylums. These idealistic, well-educated young people of middle class backgrounds became willing participants in a drive for change once they viewed the "snake-pit" conditions they encountered within the institutions (Heseltine, 1983). The following is an eye-witness account of the situation in Whitby Psychiatric Hospital, located outside Toronto. The time is 1958 and the speaker is Cyril Greenland, one of the founders of the Griffin-Greenland Archives at Queen Street Mental Health Centre in Toronto.

“The over-crowding caused a tremendous amount of violence. The job of the attendant was to deal with violent situations so big bruisers were preferred to little people. Violence was used as a method of control and that in turn created violence and so there were punch-ups all the time.

Paraldehyde was used basically for controlling violent and agitated patients. It had a terrible smell. . . which you never forger once you've smelled it. . . . Gallons of it were poured down the throats of patients.” (Greenland, 1988)

The third factor which contributed to the deinstitutionalisation movement was the discovery of psychotropic medications (Heseltine, 1983). These new drugs promised to cure all but the most severe cases of mental illness. As a result, asylums were recast as hospitals where mental illness was equated with physical illness. From now on, people were expected to require only brief admissions for stabilisation and then they would be returned to the community.

The final factor was that asylums had become money-guzzling millstones and politicians longed for a cheaper alternative (Minkhoff, 1987). Thus, the initially modest concept of brief treatment followed by discharge evolved into a full-blown movement known as deinstitutionalisation, a massive multi-national evacuation of psychiatric institutions.

As with the asylum movement, de-institutionalisation had an enormous effect. In Canada, two thirds of the 35,000 beds in psychiatric institutions were closed over a 16-year period (Heseltine, 1983). Also, like the asylum movement, unintended problems began to arise almost at once. The budgets of the remaining institutions consumed as much money as the whole system had before (Minkhoff, 1987). Families were astounded to find almost forgotten relatives once more on their doorsteps. Communities were simply not as welcoming as had been hoped. In addition, psychotropic medication failed to produce the promised cures and as a result, thousands of people found themselves persistently psychotic, frightened and alone (Minkhoff, 1987).

Since these unpleasant results had not been anticipated, necessities like housing and financial assistance were generally unavailable. Aside from families, unscrupulous boarding home operators provided the only alternative housing (Blake, 1985/86). Many ex-psychiatric patients, facing life in these filthy and unsafe houses, deteriorated further. Attempts to return them to the institutions from which they had been discharged coupled with decreasing lengths of stay originated what is known as the revolving door syndrome (Minkhoff, 1987). Other ex-patients took their chances on the streets.

Common Themes

Each of these three movements conforms to Goldberg's (1991) definition of a social movement presented at the beginning of this paper. Each movement has an ideology, a goal, leadership, a membership, a life cycle, an "us" (who saw the problem) and a "them" (who had created it). Beyond these commonalties, each of the three events share other characteristics.

First, the abuses which sparked the movements are startlingly similar regardless of the century in which they were reported. Again and again, first person accounts refer to the humiliation of nakedness, the ingestion of caustic or harmful substances as treatment,

violence as a means of control, and enforced confinement. Second, each movement drew upon society's more privileged groups for its membership. Third, the asylum and deinstitutionalisation movements (the mental hygiene movement, less so) had enormous effects and contemporary members might have pronounced themselves successful. Historians, however, have been less kind. Critics point out that all three movements began with the shared goal of improving the lives of the insane or, more recently, the mentally ill and all, in the end, failed.

Accounts of reform efforts, such as the three I have just reviewed, tend to explain failure in two ways. First, historians may take a "we blew it" perspective where "the gap between rhetoric and reality is so vast, that either the rhetoric itself is deeply flawed or social reality resists all such reform attempts" (S. Cohen, 1985, p. 19). Alternatively, they adopt an "it's all a con" view which is based on the idea that "everything that has occurred [has been] ordained by the needs of a capitalist social order" (p. 21).

Dain (1980) would agree with the latter viewpoint. According to him, progress as defined by each movement amounted in effect to a series of improved methods for social control, principally because those directing the reforms (us) were from the same social classes and groups as those perpetrating the abuses (them). As Dain explains it, "Therapy and humane care [are often] contrasted with the desire to rid society of a disturbing class of people" (p. xxvii).

The only movement which might escape the charge of disguising obvious social control as help is deinstitutionalisation. However, it could be argued that the purpose of psychotropic medication is, in fact, chemical control. This new method of control was not only highly profitable, it also promised to end the expensive necessity of having to physically confine the "mentally ill." In S. Cohen's (1985) words, deinstitutionalisation cast "wider, stronger and different nets" (p. 38) and succeeded in shifting the locus of state control from the body to the mind.

Additionally, as the second part of this paper will show, the deinstitutionalisation movement had little or no effect on reports of abuse within the asylums that remained. It also released enraged and disillusioned middle class patients along with the poorer "mentally ill." These ex-patients, particularly those who were well-educated and articulate, were well equipped to organise and lead their own protest, the consumer and psychiatric survivor movement.

Theories Regarding "New" Social Movements

Given that the present ex-psychiatric patients' movement is a contemporary protest, it is useful to review briefly theories which attempt to explain what are being termed "new" social movements. For example, Mayer (1991) points out that today, the term social movement embraces a multitude of social protest and reform activities; peace, environmental, gay and lesbian, and women's movements are a few examples. Melucci (1989) adds that current day society has fostered the development of a different form of movement. Today, contemporary protests have become part of the fabric of social life unlike the French revolution, for example, where discontent built over decades, finally exploding in one all-encompassing transformation.

J. Cohen (1985) defines what is specifically "new" about these movements. She states that people have begun "contesting the control of an increasing range of social activities formerly shielded from public scrutiny by tradition" (p. 701). Touraine (cited in J. Cohen) adds that "the main political problems today deal directly with private life, fecundation and birth, reproduction and sexuality, illness and death" (p. 701).

Melucci (1985) believes that the goals of these new movements are also different. First, members understand that symbolic change is an important precursor to real change. Second, they seek to make power visible. Thus, a clear understanding of the mechanisms and the uses of power becomes essential to the change process. Finally, Melucci believes that these new movements "don't separate individual change from collective action" (p. 812). In feminist words, the personal is the political.

Why a Fourth Movement?

Reports of abuse are, once again, the basis for the formation of the consumer and psychiatric survivor movement. In a 1989 CBC Radio broadcast, hosted by Irit Shifirat, a number of people told their stories:

“they took me to the "quiet room" and they ripped my clothes off, and they stuck me in the bum with needles very painfully and roughly because I was struggling to get away from them. . . . I was tied to the bed naked, and then they left me in the dark with these drugs happening that they had injected in me, and I was terrified.” (p. 11)

“A button is pushed. I was rendered instantly unconscious. . . (and) entered into convulsive seizures. A lethal electrocution consists of one ampere for one second through your brain. What we're talking about is more than half (that) each and every time. . . . On the other hand, you have just had a traumatic head injury One of the side effects of traumatic head injuries is a giddy sense of euphoria. I stopped complaining . . . and was declared another miracle cure. (These events) coincided with my 17th birthday.” (pp. 19-20)

Additionally, older members of the movement can recount the horrors of the now discontinued insulin therapy, a procedure where insulin induced convulsions and coma were thought to help people with schizophrenia and depression. Others are survivors of Central Intelligence Agency (CIA) funded experiments on brainwashing carried out in the 1950s and 1960s by the now infamous Dr. Ewen Cameron in the Allan Memorial Institute in Montreal (see Frank, 1990).

Ex-patients' stories also contain a note of betrayal because, as Unzicker (1989) states, "They'd promised to help me" (p. 71) and instead, "abuse and oppression is what psychiatry means by help, care and therapy" (Supeene, 1990, p. 231). Thus, from the perspective of those who have received psychiatric treatment, it appears that the abuses of the last two centuries have persisted into the 1990s. It remains "generally accepted as not only legal but actually therapeutic to lock people up and drug them, and apply electric shock to their brains" (Supeene, 1990, p. 213). The 1990s, however,

have revealed one additional theme. Today, many women who are confined in psychiatric institutions report experiences of sexual abuse perpetrated either by other patients or staff (Firsten, 1991). Men, too, report sexual abuse (Deegan, 1990).

What is Different This Time?

The first and most obvious difference between the three preceding movements and the contemporary drive for reform is that members of the latter are the "mentally ill" themselves, rather than interested others acting on their behalf. Certainly, deinstitutionalisation has played a central part in this new development. Previously, asylums promoted what Georg Simmel would call the "threshold phenomenon," which dictates that there is a point when the effects of oppression become so great that, "pressing the suffering elements closer together, reveals all the more strikingly their inner distance and irreconcilability, precisely by virtue of this enforced intimacy" (Simmel, 1908/1950, cited in Levin, 1971, p. 105). Thus, the extremes of oppression within asylums drove people apart while deinstitutionalization released them so that they were free to join in protest.

A second difference exhibited by the present movement is that ex-patients have split into two camps, consumers and psychiatric survivors. According to Hurst (1990), "A consumer gives in to advertising, to pressure, to the wishes of the (service) providers. A survivor has fought, endured and triumphed, like the survivor of Auschwitz" (p. 7). Expressed in extreme terms, people who call themselves survivors feel that consumers are dupes for believing that the mental health system has any value at all while survivors are tough freedom fighters. On the other hand, consumers believe that there is no shame in working for change from within the mental health system and that, in fact, the survivor brand of loud, rude criticism only delays reform.

The third difference between the present consumer and psychiatric survivor movement and its predecessors is the nature of its goals. Although the differences between consumers and survivors are reflected in their respective agendas for change

(consumers want to reform the mental health system while survivors insist on complete liberation from psychiatry), their goals are, nevertheless, consistent with those of many contemporary movements as outlined previously (Melucci, 1985).

First, members want to create symbolic change en route to real change. To do so, they have advocated for their representation (in sufficient numbers) in all activities related to the mental health system. Thus, they want to work in true partnership with mental health professionals by sitting on boards of directors and sub-committees, local planning groups, government commit- tees and task forces or any other groups involved in the decisions which affect mental health service delivery. They also want to see that these services begin to employ ex-patients as a matter of course. The symbolism lies in their presence in all aspects of these services from planning and development to delivery. Real change is expected to accrue over time, as members slowly make their presence felt.

In an effort to highlight the differences between consumers and survivors, Shimrat argues that the agenda described above '"is that of the consumer movement alone, and not of psychiatric survivors" (Everett and Shimrat, 1993, p. 16). She goes on to say that psychiatric survivors have no desire to "reform psychiatry [but instead) want to replace it with varied, inexpensive, humane ways of alleviating human misery and rage" (p. 16).

Another goal of the movement is to expose the power relations embedded in the present mental health system. Therefore, members attempt to shift the prevailing political discourse from one of forced psychiatric treatment as a form of help, to forced treatment as a violation of individual rights and freedoms. Additionally, they have identified the extreme power imbalances within institutions as a breeding ground for abuse. Thus, the enshrinement of rights is also designed to keep people safe.

Again, consumers and psychiatric survivors would pursue this goal differently. For example, the impact of consumer advocacy has been the liberalisation of the Ontario

Mental Health Act which specifies criteria for involuntary hospitalisation. Psychiatric survivors, on the other hand, believe that the law remains wholly inadequate and state that "every day in every psychiatric hospital, the laws purporting to protect the rights of mental patients are broken. Informed consent is a joke. . . . [Our goal] is to help each other get free and stay free of psychiatry." (Everett and Shimrat, pp. 13-14).

Finally, movement members are seeking individual change by establishing self help groups. In addition to providing people with a "place to be" or perhaps, a "place to work" as in the case of consumer and survivor-run business, groups can also become fertile breeding grounds for the movement itself (Gartner, 1984). In Ontario as well as Canada as a whole, self help groups have been slow to develop as contrasted to self help groups in the united States where Chamberlin (1990) describes their success as "striking" (p. 331). Susan Hardie of the National Network for Mental Health (a Canada-wide consumer and psychiatric survivor organization), believes that the reason for this disparity is related to one of the down-sides of the Canadian social welfare and health care systems; dependence on the part of recipients. In Canada, the establishment of, especially, the politicised variety of self help, can become interpreted as biting the hand that feeds. Hardy goes on to say that many self-help initiatives in Canada have also had a strong professional presence (personal communication, March 1993).

In an effort to outline psychiatric survivors' perspectives on self-help, Shimrat states: “Self help groups "run" by social workers . . . keep ex-patients dependent. . . . I feel that survivors' goal is the development of alternatives to psychiatry, beginning with independent mutual support and the freedom and safety to say what happened to us in the system and what we really feel.” (Everett and Shimrat, p. 15)
Given the above emphasis on the difference between consumers' and survivors' goals for change, it is not surprising that Shimrat believes that ex-psychiatric patients have, in fact, formed two separate social movements, one with a reform agenda (consumers) and one with a liberation agenda (survivors). Emerick (1991) would agree. In his analysis of politicised psychiatric self-help groups, he found that consumer and psychiatric survivor groups had distinct internal and external interactional patterns.

Consumer groups had more contact with traditional professionals and less among themselves while survivor groups displayed the opposite behaviour, more interaction among themselves coupled with very little contact with professionals.

However, there are other viewpoints which indicate that it remains a matter for debate as to whether or not these are two, distinct movements or, as Spano (1982) would say, simply two sides of the same reform coin. S. Cohen, (1985) seems to support Spano's viewpoint. From Cohen's perspective, both groups seem to espouse forms of "destructuring ideologies" ...[which] owe their public appeal to the rhetorical quest for community" (p. 116). One group's goals for change may be more limited than the other's, and ideas about how these goals are to be accomplished may vary but, as Shimrat herself states "we all need what everybody else needs. . . love, dignity, respect, work, money, leisure, space, freedom, privacy, sex, fun, [and] self-expression" (Everett and Shimrat, p. 28).

A final point which supports the idea that consumers and survivors are members of a single, albeit divided movement, is offered by recent research on the process by which social movements frame their ideology. Neidhardt and Rucht (1991) state that "factions within a social movement usually compete with each other in the framing process" (p. 445). In other words, the fact that consumers and survivors have ideological differences, even deep ones, does not presuppose two separate movements.

From my perspective, a far more salient issue is the process by which consumers and survivors have identified and expressed their differences. Simmel (1908/1950, cited in Levin, 1971) will confirm that it is typical for members of oppressed groups to be even more angry with one another than with their oppressors. In real life terms, however, anger is expressed in both the consumer and survivor factions by infighting, backbiting and personal attacks. These seemingly endless battles sap the energy of members and turn their attention from protest activities to endless internal wrangling.

Shimrat confirmed this perspective and described her experience with the Ontario Psychiatric Survivors Alliance (OPSA):

“Anger was a huge problem during the time I spent working for OPSA. Many of us were afraid of our own and other people's anger and almost everyone was angry almost all the time. People who got paid endured continual attacks on our integrity and competence from others who did not. And there was a notion (not applicable to paid staff hut otherwise inviolable) that no matter how badly someone behaved, they had to be treated indulgently because "we're all survivors and we don't want to treat each other worse than the system treated us." Thus there was a reluctance to point it out, never mind try to do something about it, when someone acted in a way that was detrimental to the organization.” (Everett and Shimrat, 1993, p. 22).

As the foregoing discussion of the three historical movements suggests, success is best determined with the benefit of hindsight. However, one indicator of success is provided by Mayer (1991) who states that successful movements offer ideas which are simply an "extension of basic liberal concepts which dominate . . . public philosophy" (p. 57). In other words, movements usually seek to broaden established rights and freedoms rather than redefine them. I would argue that Mayer's statement exactly reflects consumer goals for reform. I would further contend that the psychiatric survivor goal of setting people free from psychiatry and psychiatric medication through inexpensive alternative approaches is well within what are, now, rather wide and pluralistic public opinion boundaries. Liberation discourse is, in many ways, the hallmark of contemporary social movements and "one of the most popular destructuring ideologies" (S. Cohen, 1985, p. 130).

However, I would like to move the discussion out of the realm of theory by referring to a current and concrete example of how consumers and survivors have affected reform. The Ontario government has recently released its mental health reform policy which is contained in a report entitled Putting People First (1993). Thus, it is possible to examine how the movement's stated goals mesh with the basic elements of the policy.

The policy document, in essence, announces a second wave of deinstitutionalisation. Specifically, it is the Ontario government's intention to close one half of the remaining psychiatric hospital beds by the year 2003 (reducing levels from 58 per 100,000 population to 30 per 100,000), and reallocate the expected savings to four community-based initiatives; "case management, 24-hour crisis intervention, housing, and supports planned and run by consumer/survivors and families as alternatives to the formal mental health system" (Putting People First, 1993, p. 17). Clearly, this document is a re-working of the destructuring ideology of the 1960s and 1970s summed up by S. Cohen (1985) as, "small is beautiful, people are not machines, experts don't know everything, bureaucracies are anti-human, institutions are unnatural and bad, the community is natural and good" (p. 35).

If the policy is assessed in terms of how it addresses consumers' and survivors' goals for change, the following points can be made. First, large numbers of consumers and self-declared survivors participated in a variety of planning groups that culminated in the production of the report. In fact, they were aggressively recruited as participants. Thus, the movement has had a substantial part in the present reform direction and, I would argue, has achieved its goal of participation. Additionally, the report enshrines continued consumer and survivor participation in its rhetoric so that movement members are virtually guaranteed places at future decision-making tables.

However, it is important to note that participation from the movement's perspective is defined as "partnership" - but evidence contained in the report suggests that partnership has not been achieved. For instance, the language of the report reflects the traditional one-down medical-model discourse in that it, in one example only, labels consumers and survivors as "cases" and service providers as "managers." Clearly, this type of terminology is a strong negation of the equality that partnership implies. The spectre raised by this critique is, of course, that of co-option (Goldberg, 1991). The question which must be posed is, have consumers and survivors truly become partners in the mental health reform process?

The second goal of the movement is to expose and critique the power relations which drive the present mental health system. On this point, the report is silent. However, it might be argued that reform-directed hospital bed closures, consistent with past deinstitutionalisation philosophy (S. Cohen, 1985), imply that "had" institutions (besides being more expensive) are more likely to violate rights and abuse patients while "good" communities do not. This supposition is untrue on two levels. First, communities regularly neglect, harass and victimise their more vulnerable members (White, 1992) and, further, formal government-sponsored community mental health programmes are quite capable of violating rights and abusing their clients.

Additionally, White (1992) states that the extensive network of community services which is supposed to replace psychiatric institutions are, in themselves, "'institutional', although they lack the stone walls of the traditional institution" (p. 94). Thus, the question for consideration is, are we once again preparing to cast S. Cohen's (1985) wider, stronger, different (and perhaps, less visible) nets?

The third consumer and survivor goal is the establishment of self-help. Indeed, the report calls for the funding of "consumer/survivor. . . initiatives that help people help themselves" (Putting People First, 1993, p. 7). It cites the two-year old government-sponsored Consumer/Survivor Development Initiative (CSDI) which has already funded 36 projects in Ontario as the prototype for continued activities in this area. CSDI, of course, it not without its detractors. For example, Dianna Capponi (1992), in a keynote address to an audience of consumers and survivors argued that these projects have sapped the passion from the movement and replaced it with eternal wrangling with government bureaucrats over ever-inadequate funding dollars and other complaints.

I believe Capponi's points are well taken. Many consumer and survivor groups appear to be struggling to learn the skills required to administer the funding they have received. Additionally, the government has required them to establish complex non-profit corporate structures long before they have had a chance to define for themselves

how their organisations should look and operate. Throughout this process, many groups have complained of a lack of training and inadequate support from government bureaucrats. The question Capponi and others raise is, can consumers and survivors deal with the demands that government funding imposes and still have the time, energy or will to take the strong anti-government stances their change-agenda requires?

It appears then, that the key to the success of the consumer and survivor movement may rest upon how its members choose to answer the questions raised by this discussion: Is participation the same as partnership? Have they endorsed a mental health reform document (in Ontario) that merely dresses old social control agendas in new rhetoric? Finally are consumers and survivors being co-opted through government funding programs?

It is regrettable to have to close without being able to provide answers to these questions. Given that the consumer and psychiatric survivor movement is in its infancy relative to its three predecessors, it is indeed risky to predict its future. Nevertheless. I believe it has two concrete achievements to its credit. First, it has succeeded in securing a promise from government that, from now on, its members will be present at most mental health decision-making tables. Second, although far from perfect, the language of reform (using the policy document Putting People First as an example) has become less jargon-ridden, more concrete and more respectful. Often, the power of language is under-valued and subtle changes are considered unimportant. However, feminists, who have fought their own language battles, would be the first to acknowledge the significance of this change. Thirty years hence, others will be able to look back on this latest mental health reform effort and more accurately judge the extent of the effect of the consumer and survivor movement. Meanwhile, present-day observers will have to wait and see.

Conclusions

Given that the historical review portion of this paper indicates that little has changed in 300 years, it tends to leave a "What's the use!" feeling. Historical reviews are also inclined to subject the passions of social protest to rather emotionless theoretical judgements, thereby providing only a pale representation of once blazing debates. Fortunately, the present mental health reform effort has placed us in the midst of yet another contest for power and it serves to remind us that intense emotions (both hopeful and despairing) are inherent in such struggles. Additionally, there is a new player in the game this time and thus, we cannot automatically assume that the consumer and psychiatric survivor movement will meet the same fate as its predecessors. Nevertheless, I believe we must heed Eliot's elegantly phrased warning, "Between the idea and the reality, between the notion and the act, falls the shadow" (quoted in S. Cohen, 1985, p. 93). In plainer terms, we have to walk the walk as we talk the talk. The Ontario plan for mental health reform provides the talk and goes on to predict that it will take ten years to achieve the walk. In the meantime, consumers and survivors can ponder the questions this analysis has raised. However they may choose to answer them, I believe we can rest assured on one point: the ground is shaking. Something is happening.

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