

BEYOND "BAD MANNERS": THE POWER RELATIONS OF "CONSUMER PARTICIPATION" IN ONTARIO'S COMMUNITY MENTAL HEALTH SYSTEM

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ABSTRACT

This article describes the work of the legislation subcommittee of the steering committee responsible for the implementation of the Graham Report, Ontario's current blueprint for community mental health. It describes barriers to psychiatric survivor participation in the subcommittee's 1990 provincial consultation, including professional/bureaucratic characterization of survivor actions during the event as "bad manners." I argue that this naming is an act of power. Conflicts arose because the two groups operate from different behavioural codes in which the pivotal issue, acted out indirectly in all kinds of interactions, was whether and how deeply to include personal experience and emotions as forms of knowledge. The cultural dimensions of "consumer participation" must be more broadly recognized and more consciously considered if this policy is to remain viable, particularly in a time of major economic restructuring.

INTRODUCTION

In 1983, I moved from Saskatchewan to Toronto. Uprooted from clinical work in a children's mental health centre, I took a job with the national office of the Canadian Mental Health Association (CMHA). For the next four years, through a project known as "Building A Framework for Support," I was involved in attempts to establish "consumer participation" as a policy of that organization. Consumer participation in the community mental health field is generally understood to mean establishing and/or increasing representation by "consumers" or "survivors" of psychiatric services within the system's decision-making bodies (e.g., boards of local agencies, regional health councils, provincial committees). My work on the Framework Project brought me into collaboration with psychiatric consumers/survivors for the first time.¹ It raised questions about the power relations of that process with which I continue to struggle.

In 1989 I left the CMHA and became a doctoral student in sociology at the Ontario Institute for Studies in Education (OISE). I was driven by a desire to understand more about psychiatric survivor participation in making mental health policy.

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The most profound lesson of my return to university was captured by C. Wright Mills (1957) when he admonished thinkers within scholarly communities not to split their work from their lives, to learn instead to use their life experiences in intellectual work. My doctoral research began with persistent, nagging, frustrating, burning questions about my own practice first as a mental health organizer and then as a researcher. It called upon all my life experience as I was initiated into the complexities of the psychiatric survivor movement. Guided by two prominent survivors, I spent three years observing, documenting, and organizing support for survivor projects (Church, 1991, 1992). I also researched how "consumer participation" was and was not enacted by a government-appointed committee investigating the possibilities for community mental health services legislation in Ontario.

Throughout this engagement, I was confronted with the complexities of situating myself in relation to a social movement whose members have historically been oppressed within service systems run by people like me. In their attempts to deal with this contradiction, survivors demanded of me a particular kind of participation: they wanted me to be personal. This meant disclosing pieces of myself I have been trained to keep private and separate in order to properly fulfil the roles of service provider, organizer and researcher. Taking up this challenge, I moved through a process of personal and professional deconstruction. Ironically enough, it included a period of both physical and emotional breakdown.

These are some of the experiences which frame my understanding of the power relations of the community mental health system in Ontario. This article pulls a single thread of argument from the total fabric. In it I revisit the provincial government's consultation into community mental health services legislation, specifically key encounters which occurred between consumers/survivors and professionals/bureaucrats involved in the process.² The latter invariably emerged from these encounters feeling upset or even abused by survivor expressions of distress and/or anger—expressions which, for lack of a better analysis, were frequently categorized as "bad manners." I want to both describe this dynamic and begin to talk about it differently.

EARLY DEFINITIONS

Some of the first work on "consumer participation" within the community mental health field in Canada was done by the national office of the CMHA through the Framework for Support Project. Published by the Association in 1986, a ground-breaking document entitled *Participating* (Hutchison, Lord, & Osborne-Way, 1986) defined "consumer participation" as the process of involving people who have directly experienced a mental health problem in two primary spheres: all aspects of planning and decision making within service systems, and all aspects of their work, leisure, and volunteer activities within the community. The first major barrier to participation was viewed as "within" individuals in the form of hesitation and/or lack of self-confidence. Suggested strategies for overcoming this problem included building support networks, gaining access to community resources, and increasing access to necessary information. "Social" in character, the second major barrier included exclusionary attitudes and actions as well as structures/policies which limited the resources available to consumers for planning and development.

Suggested strategies for overcoming this problem included the development of systemic plans for organizational change, retraining of board and staff members, and documentation of the change process for communication with other groups.

Participating was followed two years later by the publication of *Consumer Participation: From Concept to Reality* (Pape, 1988). The value of this publication was in its documentation of serious attempts to operationalize "consumer participation" within the CMHA itself and its articulation of some general policy implications. Suggestions included the appointment of consumers to commissions, task forces, and regional planning bodies as well as developmental funding for self-help, natural network building, and brokerage which would facilitate allocation of dollars directly to individuals for managing their own service needs. A strong affirmative hiring policy was recommended as were innovative work options.

Reviewing these documents almost 10 years after their release, I am struck by how "reasonable" their contents are within the context of liberal democratic societies. Simultaneously, as someone who was involved in creating them, I know that they were contentious and that the changes outlined continue to be difficult to implement. The conclusion to *Participating* alludes to the underlying social-political dynamic:

Consumer participation is never an unemotional topic. It challenges service providers to rethink how they plan, direct and deliver human services, and to address the issue of power reversal to effect significant change in people's lives. It challenges the Canadian Mental Health Association as an organization to re-think its purpose and its understanding of how to respond effectively to need. It challenges all of us to work locally for the creation of more responsive communities. People who respond to these challenges are breaking new ground (Hutchison et al., 1986, p. 53).

While cautiously stated by the CMHA, consumer participation is about power and the redistribution of power (Barker & Peck, 1987; Church & Reville, 1989; Church, 1992; Church, 1993; Church, 1995; Derksen & Nelson, 1995). It has major implications for mental health professionals who run agencies and organizations as they attempt "to realign their relationships with clients in keeping with the mutually collaborative and broadly consultative approach which users of service are seeking" (Church & Reville, 1989, p. 24). Those who have taken up this task have indeed broken new ground. After a decade of grappling with "consumer participation," it is now possible to be more precise about the nature of that ground and the unsettling quality of that breaking.

RESEARCH METHODS

The focal point for the emergence of "consumer participation" in Ontario was *Building Community Support for People*, the government's blueprint for community mental health (Graham, 1988). Known as the Graham Report, its central thrust was that, by 1990, regional health planning bodies (District Health Councils) should create comprehensive mental health plans which targeted the "seriously mentally ill" as a priority. It supported the principle that consumers of service be fully involved in the ongoing development of mental health services, and envisioned a system which would foster partnerships among consumers, families, service providers, and government. The Graham Report entered its implementation phase

with the striking of three committees: a steering committee, an implementation strategy subcommittee, and a legislation subcommittee.³ Under the direction of the steering committee, the implementation strategy subcommittee was charged with the responsibility of advising government on the implementation of all 19 Graham Report recommendations—except for one. The recommendation on community mental health services legislation became the responsibility of the legislation subcommittee.

The legislation subcommittee was to advise the Ministry of Health on taking "... a leadership role to develop legislation to provide for the essential functions related to a community-focused mental health system using a broadly-based consultative process" (Graham, 1988, p. 11). In keeping with its mandate, the subcommittee sponsored a provincial consultation in the spring of 1990. District Health Councils (DHCs) were given the responsibility of coordinating regional meetings; staff were asked to take an active outreach role in ensuring consumer involvement in the process. The subcommittee travelled to seven communities to listen to presentations: Hamilton, Kingston, Thunder Bay, Ottawa, Sudbury, London, and Toronto. On the basis of these discussions, members wrote their final report, a document which featured 25 recommendations (The Legislative Subcommittee of the Steering Committee on the Implementation of the Report of the Provincial Community Mental Health Committee, 1991). Although this report was never acted upon, the subcommittee's work remains significant. It was here that consumer participation was introduced to and took hold of the Graham implementation process in a substantive way.

I became involved in these events as a contract employee of a group called Toronto Psychiatric Survivors. On its behalf, I tracked psychiatric survivor participation in the public hearings by conducting a snowball sample of 60 telephone interviews, collecting consultation descriptions from various public sources, attending three hearings, and organizing an "exit interview" with members of a self-help group after their appearance before the legislation subcommittee. My key informants included survivor movement activists, DHC staff, patient advocates in psychiatric hospitals, staff of community programs, and other individuals known to be keen observers of the community mental health scene. I kept detailed notes which I transcribed into short descriptions and analyzed for common themes. These formed the basis for a brief entitled *Do the Right Thing* Right*, which was presented to the Toronto hearings (Church & Reville, 1990).

A year later, working independently, I interviewed 21 people who were instrumental in how the consultation was put together. They were identified primarily through the network of contacts I had built up in my initial investigation. Ten of my interviewees were Ministry of Health employees. They included a deputy minister, an assistant deputy minister, branch directors, program or unit heads, and consultants. All were doing jobs oriented to health policy and planning. Four of my interviewees were government appointees to Graham committees from the community sector of the service system. One was doing community work from an institutional base; another was a community-oriented advocate concerned with monitoring patients' rights in psychiatric hospitals. A third participated in the process as a "citizen" representative; the last was the director of a provincial mental health organization. Seven of my interviewees were consumers/survivors who

were also government appointees to Graham committees. This group included a provincial politician and a retired corporate vice president as well as three survivors who were on some form of disability insurance/pension and two who had service system-funded jobs related to survivor involvement.

Foucault's (1981) discussion of method suggests that, in documenting social practices, the researcher should attend to what is said, what is done, the rules imposed, the reasons given for those rules, plans formally documented, and rules/plans taken for granted. I used this framework as a general orientation for the interview schedule. I did some initial "free form" interviews designed to give me a broad overview of the consultation. Once these were done I revised my questions to focus specifically on key points of interplay in the negotiations between consumers/survivors and bureaucrats/professionals. Interviews took place over several months from February to April 1991. Some were done face to face; others by telephone. They varied in length from 30 minutes to an hour and a half. They took place in restaurants, bars, government offices, and people's homes. All interviews were taped and transcribed. The transcripts enabled me to create an account of events leading up to and constituting the legislation consultation (Church, 1993; 1995). The following section draws heavily on this material.

REAL LIFE DYNAMICS

With the best of intentions the Subcommittee embarked on its consultations but found a variety of problems and obstacles to meaningful involvement by consumers/survivors. As time went on, some of the difficulties being experienced were addressed, but not all. The consultation process was a powerful learning experience for Subcommittee members both in terms of people and process. The knowledge gained from the process will be extremely valuable in enabling the Ministry of Health to "do it right" in future consultations (The Legislative Subcommittee of the Steering Committee on the Implementation of the Report of the Provincial Community Mental Health Committee, 1991, p. 4).

In 1987, when the committee which developed the Graham Report was appointed, it drew its membership primarily from three sectors: institutional psychiatry, community mental health programs/agencies, and government. There were no consumer/survivor members. This committee was supported by an informal research group of seven or eight individuals all of whom had deep roots in community services. The contents of the Graham Report were negotiated between the official committee and its shadow research team following a series of provincial hearings at which there was virtually no survivor presence. Neither community mental health services legislation nor consumer participation was central to the deliberations of the original Graham committee. Both were inserted into the debate by staff and/or research team members for whom these were significant issues.

The three committees responsible for implementing the Graham Report began to meet in the spring of 1989. When they were first established, none had consumer/survivor representation. From within its ranks, members representing the Advocacy Resource Centre for the Handicapped and the Psychiatric Patient Advocate Office made this an issue for the legislation subcommittee by refusing to constitute consumer/survivor representation. "In hindsight," said one respondent,

"it was an omission. It wasn't a conscious attempt to keep consumers out. It was just that nobody . . . it wasn't in the (bureaucratic) 'file drawer'." The deputy minister himself remedied the situation when, after a visit to a Toronto drop-in centre, he gave the green light to committee membership for the first official psychiatric survivor representative.

No one expected that the discussion of community mental health services legislation would become contentious and dynamic. According to one respondent, the bureaucratic view of things at the time was that legislation would be a ". . . dry, technical area . . . a kind of navel-gazing research exercise." This expectation was transformed in large measure by the presence, eventually, of three consumers/survivors on the subcommittee. It was transformed by the participation of large numbers of consumers/survivors at the seven regional hearings which constituted the consultation. Survivor representation on both sides of the discussion table created problems in processes which had previously been taken for granted.

"Kind of confrontational"

The first major negotiation between psychiatric survivors and mental health professionals occurred as the legislation subcommittee prepared to host the consultation. It took the form of several "sensitization" sessions which survivor committee members organized to ensure that professional/bureaucrat members of the committee learned what to say and what not to say to consumers/survivors who appeared at the public hearings.

Small informal meetings were held at which professional committee members worked through a series of prepared questions prior to listening to a handful of survivors tell their stories. For some of the speakers, it wasn't an easy experience. One of them confessed: "I had never presented in public before . . . I am a private person. I don't like to do this sort of thing." Although some professional/bureaucrat members admitted to discomfort at the confrontational tone, the reviews were generally positive; the criticism delivered was perceived as "supportive." This cautious acceptance of survivor perspectives was then immediately put to the test.

As plans were made for travelling to the various hearings, conflicts developed over which consumer/survivor committee members were going where and how costs for their attendance should be paid. Bureaucrats responsible for the subcommittee were pressed to recognize the difficult financial circumstances of these members and to advance them sufficient funds to cover the cost of their involvement. Unfortunately, the bureaucracy was set up for reimbursement only. Heated exchanges over train tickets, taxi chits, hotel and restaurant bills threatened to derail the consultation before it got underway. A small walk-out was threatened. In response, bureaucrats at several levels tried desperately to learn how to provide support while hemmed in by structural barriers which frustrated them almost as much as they did survivors. It took awhile before plans could be made to "boot-leg" the necessary funds through community agencies. In the meantime, bureaucrats struggled to make things work by paying for survivor expenses on personal credit cards, hoping to be reimbursed themselves later on. The entire situation "set committee members' teeth on edge; everybody was mad at everybody else."

"Say what you want to say?"

Beyond these seemingly mundane dramas, there was concern among psychiatric survivor leadership about whether and how members of their constituency would be enabled to speak out in public. The agenda for the regional meetings was organized around a document which featured 14 general questions. It directed the reader's attention to a very particular set of issues: the scope of the proposed legislation, centralization/decentralization, geographic units, authority structures, regional mandate and financing, service coordination, enforcement of standards of care, record keeping, and confidentiality.⁴ The thought of discussing legislation in these terms was intimidating to service providers and consumers/survivors alike; most people found the document's contents terribly complex.

Consumers/survivors, in particular, assumed that the issues were beyond their comprehension. In spite of this, their leadership encouraged as many representatives as possible to attend.

Come to the hearing . . . Make a presentation. There is time set aside for us. Tell your own story. You could put in a written brief, too, if you want. Don't worry about the questions in the discussion paper. If the questions don't interest you, leave them. Say what you want to say (Reville, 1990).

It is difficult to gauge the impact of this effort to give consumers/survivors both the opportunity and the permission to speak. What is clear is that survivors attended the legislation consultation in unprecedented numbers and that in their comments, however brief or unprepared, they raised issues which were outside of the established framework—issues which were initially rejected by some committee members as "horror stories."

My strongest memory here is of a young woman who told the subcommittee a painful story of her life both in and outside of hospital. In the awkward silence which followed she began to cry. "It's no good for you to send committees," she lamented. "Unless you actually *do* something, the next time you come back, I'll be dead." Many consumers/survivors reinforced this message. In its final report, the legislation subcommittee acknowledged that what members heard:

. . . was unmistakable and poignant. Many psychiatric consumers/survivors in Ontario have been condemned to a life of poverty because of reactions to their illness. Many people who spoke to the subcommittee members have experienced at least two levels of trauma—first, their illness; and second, their hospitalization or "treatment." In fact, people are disabled both by their illness and by the mental health system. We also heard many frightening stories of the disabling results of psychiatric medication (The Legislative Subcommittee of the Steering Committee on the Implementation of the Report of the Provincial Community Mental Health Committee, 1991, p. 4).

Ultimately, there were two distinct streams of discussion within the consultation, one engaging mental health professionals and the other engaging consumers/survivors. For the most part, professionals addressed the issues as they were framed by the consultation document. They talked about decentralization, regionalization, local authority, mandates, funding mechanisms, treatment models, professional autonomy, and target populations. With the exception of a few formal briefs (see, for example, Ontario Psychiatric Survivor Alliance, May 1990), consumers/survivors talked primarily about their experiences of the mental health system and their lives in the community. They talked about hate, prejudice, and

poverty; about self-help, capacity, and power; about loss, suffering, and struggle. They asked to be included. They paid tribute to each other. Some of them cried or were openly angry about the poor quality of their lives in Ontario communities.

The tension around this challenge to the subcommittee's agenda was heightened by a major debate which arose over the nature of interactions between subcommittee members and people making presentations. Specifically, professional/bureaucratic subcommittee members were uncomfortable with one particular survivor member who consistently confronted professional presenters on the content of their remarks. From this survivor's point of view, the subcommittee was there to collect information which would form the basis for its final report. It seemed logical, therefore, to check on the information, to get at the facts. But her "grilling" of certain presenters was considered improper. Professional/bureaucratic subcommittee members pressed her to be less intimidating, more "reasonable," in her dealings with the variety of people who appeared before them. As another survivor member recalled: "We could ask questions but only of a particular kind. We didn't have the right to editorialize or anything like that. Clarification. No editorializing."

"Haggling over what's important"

When the consultation was over, the subcommittee plunged into confusion and dissension over producing a final report. Members had at their disposal transcripts of each of the seven public hearings as well as written submissions from 150 local organizations. The problem was how to make use of this massive amount of material. For their part, survivor members were eager to stick to the transcript material, to see that the final report responded to the hearings; the arena in which they had scored some major points. But writing the final report was a fresh battleground. Professional committee members saw the consultation as one source of data and presumed that other research and literature should be brought to bear. When it came to the task of putting recommendations in black and white, some professionals, who had earlier been willing to let some issues slide, started to take tougher stands.

Gradually, there was a break with the public hearings and the transcript material. Subcommittee members reverted to the interests they represented as their primary reference point rather than using the collective process which they had just been through as a fresh starting point. A tremendous amount of conviction had developed among them in support of the consumer/survivor message that jobs, income, and housing were crucial systemic issues. Even so, survivor members had to fight to get these issues included in the final report. Within these discussions, survivor members viewed their professional "partners" as too system-focused, too protective of the existing system. As one of them put it, professionals/bureaucrats coalesced around "saving their ass." However, by the close of subcommittee deliberations, survivor committee members had ensured that the final report took a rights approach to the issue of legislation.

The recommendations began with a statement of values including self-determination, liberty, and affirmation of human rights. Among other things, they pressed for legislation which would include a statement of rights for people who use mental health services as well as their families. They sought a complaint/appeal

process regarding admission and discharge from services, and access to the courts for individuals/groups to enforce their rights. While not necessarily disagreeing with this orientation, professional/bureaucratic members of the committee felt that crucial issues with respect to the actual operation of the system were not addressed. "The report doesn't talk enough about how you are going to change the system. There isn't a lot in there around systems, about the actual funding, the dollars," noted one respondent. While recognizing bureaucratic unhappiness with the report's vague structural understanding, another respondent posed a larger question: "What is the real effect of the report? How will it get translated into legislation and what will happen programatically?"

EAVESDROPPING

Participants on all sides of the legislation consultation were left with unresolved feelings, but this was particularly true of professionals/bureaucrats who had sustained involvement in the process. They suppressed a tremendous amount—emotions which lingered on for months afterward. Using direct quotes from my respondents, I have created a dialogue which communicates a sense of their feelings about their experience as well as their opinions of consumer participation. If professional/bureaucratic comment could be condensed into a single conversation, it might read something like this:

First voice: (cautiously) I felt that some of the consumers were a bit too impatient with the Ministry people trying to get the whole thing done. There are obvious rules, we all have rules, frameworks that we operate within. I thought at times they were making things very difficult for the Ministry people. They could have been a little bit more cooperative, collaborative in terms of organizing things.

Second voice: (lots of emphasis) There were *all kinds* of incidents that occurred over the organization of the consultations themselves that really set the committee members' teeth on edge. Everybody was mad at everybody. The only reason things didn't fall apart was because the bureaucrats bent over backwards to make it happen. If they hadn't I am sure everything would have fallen apart somewhere in the middle. I never would have put up with what the staff put up with. It was just unbelievable!

Third voice: (hurt) When you had somebody who treated you really badly, you just had to sit there and take it. You couldn't say "that's not acceptable." Consumers were allowed to stomp out of the room. Figuratively speaking, they were allowed to tell us that we were assholes. We didn't have much of a public outlet. When people were angry there was really very little we could do with it other than to talk to other bureaucrats. But there were occasions when I would have liked to tell people off.

Fourth voice: (remembering) I had a great deal of difficulty looking at things through the eyes of consumers. I have been through some pretty difficult times over it. The subcommittee was yelled at during the consultations. One person stood up and shouted "We are going to make you people hear us. Don't ever forget it! Damn it!" And I went to bed that night very upset. I couldn't sleep. I did not agree to work on the committee to be yelled at.

Second voice: (wryly) Yes, some consumers made life very unpleasant. The committee meetings came to be things that nobody wanted to go to. They were adversarial. People were at other people's throats. We tried to arrange things to give consumers their due, maybe to convince them that professionals are all right, that we are not all three-headed monsters.

First voice: (still cautious) I felt sympathetic, almost a bit distressed about what the Ministry people were having to do to meet the demands that were being made of them. There seemed to be an ongoing tension in the process over whether they were going to be able to meet the standards consumers were setting for this whole thing. They could have taken into consideration a little bit more about what they were subjecting these Ministry people to.

Fifth voice: (trying to be fair) The hardest thing for me was not getting too defensive which I do at times when I feel like I am doing the "right" thing and get dumped on—or if I have an opinion that gets negated. There was almost a feeling that if you weren't a consumer you couldn't possibly have anything valid to say. At times that just pissed me off. At other times, I could understand it.

Third voice: (summarizing) Their presence challenged my assumptions about things and my comfort level with processes. I found on occasion that I felt uncomfortable and guilty. If you work for the government you have to buy into some sense of due process—that this is the way change gets done. Otherwise we would be on the outside screaming. So you start to wonder if you are part of the problem.

Consumers/survivors' comments on the same process reflect different issues and concerns which, using direct quotes again, I have expressed as a single conversation. It reads something like this:

First voice: I saw the consultation chiefly as a way for our people, survivors, to bring forward their stories or recommendations. No one had ever listened to us before. I felt that I was going to make sure that every survivor who wanted to talk had the opportunity. And if I had to sit through professional presentations, I would do that too.

Second voice: (musing) The public hearings that I attended did produce some exchange between survivors and professionals in spite of the awkwardness of the situation. Considerable energy developed among survivors who managed to find their way. However, that was mainly because of the support they gave to each other rather than by any attempt by people nominally in charge of the consultation to create that energy. In fact, it appeared to me that the amount of energy made the people running the consultation quite nervous.

Third voice: (with unexpected passion) Sometimes I was upset as much by us as I was by them. I believe strongly that *anybody* who was there and who heard the words, who heard the people, who asked the questions, who was awake, went on the goddamn trips, and had their expenses paid was duty bound to listen. We had a responsibility to listen to those people whether they were service provider or survivor . . . or whatever. Whether they were someone . . . who has never done anything imaginative in their life. We had a duty to treat them as democratically as we could and to listen to them. And we didn't. As a group, we did not.

Fourth voice: (shouldering the weight of the world . . .) I got more lectures about "compromise" and "how to represent my people." I couldn't sit still at the hearings. I couldn't. There is a limit to what you can take, right? So as not to be seriously offensive, I would walk out of the room, I would hold up my cigarettes for a few minutes and then obviously be going for a cigarette. "This is not a walk-out." So this turkey followed me out one time and said, "You know, it doesn't look good if you are not in there listening to what the professionals say." I said "Well, it wouldn't look good if I spat at the guy either."

Second voice: (supportively) They tried to control us but they weren't particularly sophisticated or effective about it. The attempts were fairly familiar to me. You restrict the amount of time and create an artificial process which reduces the likelihood of messy, chaotic survivor behaviour.

Sixth voice: Survivors retained some measure of control because we aren't threatened by the powers that the chair wields or does not wield. Most of us don't have jobs that are at the mercy of anyone. We are not threatened because of who holds the purse strings. We have nothing to lose, absolutely *nothing* to lose and everything to gain.

Third voice: (agitated) Still, we were bludgeoned, mentally and emotionally beaten over the head by this stupid process. The committee was sick. It was dysfunctional. (Then with sudden amusement) Listen to me. I sound like Monty Python. I am the guy who is banging the dead parrot on the counter saying "This parrot is dead. He's joined the heavenly choir." And the people behind the counter are saying "No. He is pining. He is Norwegian and he is pining for the fjords!"

First voice: (trying to be serious as the conversation sails off into laughter) Some pieces of it worked very well. In one consultation we had closed sessions, one for survivors and one for family members. The survivors talked about the local hospital. There was so much pain. I guess I was glad in one way that they could talk about it. Maybe that would help them. The families were in as much trouble as the survivors. For the first time I realized that families certainly have legitimate concerns. I am not questioning our freedom of choice or anything like that. I am simply saying that families should group together for comfort.

Third voice: The hearings were difficult but, for me, arguing over the final report was the most frustrating part. The professionals would look you straight in the face and say "We all want the same thing. Why can't you see that?" And I kept wanting to say "Because you are lying. That's why I can't see it. I can't see it because it isn't there." So, we went merrily off in a hundred different directions creating more gaps in the system than already existed. And then attempting to plaster them over. We were trying to cover earthquake fissures with polyfilla. That's what we were trying to do with the mental health system.

Fourth voice: (definitively) All in all, I think they fucked themselves. Whether their intentions were lip service or what, the door was open and we won't let it close. So I am not too worried about what motivated them. I suspect it wasn't the best of motivations. Too bad. We saw the window of opportunity and we kicked it in.

COMMENTARY

Liberal democracies . . . function by means of narrow legal and constitutional definitions of individual freedom which are blind to the *deep structures* (my emphasis) of inequality between individuals. The exercising of power in these societies is, therefore, largely invisible (Weedon, 1987, p. 120).

What is most obvious about the account I have just constructed is that "consumer participation" is much more complex than we initially supposed. All of the professionals/bureaucrats I interviewed were supportive of the idea, but they differed on its meaning and significance. Senior bureaucrats were oriented to consumer participation as an established health policy direction; for them it was connected to managing health care costs through decentralized planning and decision making. Further down the hierarchy, the same policy was understood not just as an idea but as a process which involved real people. This was considered acceptable just as long as those people played by the established rules.

Several interviewees saw consumer participation as evidence of a government bias against service providers, and a threat to opportunities for unified action in the "community" sector of the system. This view was offset somewhat by others who viewed it as a necessary tool for system reorganization. Finally, for some of my respondents, consumer participation was a process which engendered conflict. It was confusing, unexpected, perhaps frightening. They struggled to make it fit inside their world. They were converted to it. They were silenced by it. It made them question what they knew and how they acted. As a rule, the closer a professional/bureaucrat was to direct involvement with survivors either in the committee process or the public hearings, the greater the chance that s/he had been unsettled by the contact.

My description of this dynamic is only a sketch and could be analyzed in several equally justifiable ways. Recognizing that any interpretation is partial, what I want to do (and I can only do it briefly) is tease out some less than obvious connections between consumer/survivor challenges to the knowledge/power relations of mental health policy making and expressions of emotion. To the extent that community participation is driven by a grass-roots groundswell, observes Morton Warner, it will be ". . . an unpredictable force introducing an emotive element into the planning process" (1981, p. 355). I couldn't agree more. Perhaps the most significant discovery I made while investigating the legislation consultation is that emotions were the "deep structure" of power within the subcommittee's work. While power was clearly exercised through established rituals, customs, and routines of governmental inquiries—from the terms of reference right on down to the management of expense claims—it was also exercised in much more subtle ways, through "attitude, aspiration and feeling" (Corrigan & Sayer, 1985, p. 193).

The legislative subcommittee's process revealed, released, and generated anger, fear, and pain within a context which did not facilitate the working through of those emotions. As a result, many of the people involved were left with unresolved feelings, some of which emerged in conversation with me. I remember one interview which began with my recognition that the person was angry. I simply said: "Tell me about the anger" and the conversation flowed from there. Another

person thanked me for the chance to talk about how it had been, the chance to vent some things that were festering.

Part of my work in the interviews was to allow this kind of exchange to happen. In that sense, the interviews mirrored the consultation process. There, a big part of the subcommittee's work was to include, tolerate and learn from exchanges which did not conform to what Lichtman calls the "ideal of rational self-mastery" (1982, p. 271). Members lived a palpable tension between the emotional turbulence of participants' experiences and a code of professional etiquette which implicitly defines emotionality as irrational. This was the ground for much of the contestation between professionals/bureaucrats and consumers/survivors. Could survivor stories, issues and style of presentation be deemed "rational" and thereby become more broadly discussible as part of the institutional agenda? The battle over this question is present in my transcript material as a major debate over "manners."

In a pertinent article about the politics of anger, Lyman (1981) argues that dominant groups maintain their position by teaching subordinate groups codes of behaviour such as "reason" or "politeness" which sublimate anger, for example, into nonpolitical forms of action. In this way they establish "psychological hegemony." I connect his argument with the tangible concern expressed by mental health professionals that consumers/survivors participate in the consultation in keeping with a particular "etiquette": "Don't give offence. Don't be unpleasant or adversarial. Don't complain or fight. Be nice. Be reasonable. Be considerate. Be cooperative." Giroux's (1983) description of dominant cultural capital as it operates within schools has considerable resonance here.

Certain linguistic styles, along with the body postures and the social relations they reinforce (lowered voice, disinterested tone, non-tactile interaction) act as identifiable forms of cultural capital that either reveal or betray a (participant's) background. In effect, certain linguistic practices and modes of discourse become privileged by being treated as natural to the gifted, when in fact they are the speech habits of dominant classes and thus serve to perpetuate cultural privilege (p. 269).

On those occasions where consumers/survivors either could not or deliberately did not comply with the professional/bureaucratic behavioural code, there was conflict in the legislation subcommittee's proceedings; people became uncomfortable, upset, and/or angry.

Some of the emotional management which occurred within the legislation consultation was accomplished spatially. The meeting rooms for the hearings I attended were set up in ways which were strongly reminiscent of North American school classrooms, church sanctuaries, and courtrooms. This arrangement placed the committee in the teacher/clergy/judge position.

Thus, in the church, the classroom, and the courtroom, the person controlling and regulating the activity . . . has his or her back to the wall. She or he faces those whose participation is being regulated . . . facing the door through which "the public" comes (Phillips, 1986, p. 229).

This undoubtedly had an effect on the way in which everyone participated. Significantly, the subcommittee created separate, more informal forums for consumers/survivors toward the end of the hearings; room arrangements were

consciously altered. Perhaps even more powerful than these external features, however, is the degree to which there were internalized constraints on the abilities of participants to express and deal with the situation in which they found themselves.

Strong feelings of constraint were expressed by professionals/bureaucrats—even those who were in relatively instrumental positions. It was as if they had traded the freedom to express anger, to act on feelings, in exchange for the opportunity to make changes from inside rather than outside the system. As one of the bureaucrats quoted in the first dialogue put it: "When you work for the government you have to buy into some sense of due process. That is the way change gets done. Otherwise we would be on the outside screaming." So, for professionals/bureaucrats there appear to be emotional losses or compromises which accompany "buying into due process." I want to highlight this point, but not with particular sympathy, because the resulting silence emanates from a position of relative privilege.

The legislation consultation provided consumers/survivors with the public space in which to speak. What it demanded of them in return was that they overcome all the "invisible" prohibitions against this very same speech which were built into the situation. Survivors were expected to find out about the consultation. They were expected to contact the relevant DHC in order to get themselves on the subcommittee's agenda. They were expected to acquire and decipher the subcommittee's consultation paper: "those stupid questions." They were expected to prepare an oral or written presentation which addressed the subcommittee's issues. They were expected to transport themselves, sometimes over long distances, to the appropriate regional meeting. They were expected to fund the trip themselves. They were expected to walk into settings of comparative wealth to meet with well-dressed, well-cared-for, well-educated people, and in those settings to assert the significance of their own contribution.

Consumers/survivors also struggled with internalized allegiances to the rules of the "game" being played out in the consultation. I remember one particular survivor who frequently aligned himself with the professional behavioural code because it was synchronous with his own definition of "common decency." In contrast, other survivors, particularly those in leadership roles, had their own notions about consultation etiquette. Succinctly put, they considered it rude for professionals/bureaucrats to expect partnership from them when meetings were hosted in environments which were not survivor-friendly, on topics which were not survivor-generated, using documents and language which were not survivor-accessible (Church & Reville, 1990). As well, they questioned the limits which the bureaucracy established by making "... certain topics impolite, certain tones of voice or emotions irrational, or simply defining topics as psychological and not political" (Lyman, 1981, p. 59).

Consumers/survivors who asserted this code within the consultation were frequently accused of having "bad manners." However, as I delved more deeply into the transcripts, I began to see that they weren't so much rude as they were operating from a different standard for politeness and reason. As Hochschild points out:

The rebel simply works by different rules of feeling, different standards of truth and falseness of expression, and exemplifies different patterns of aim. In not feeling as she "should," the rebel reveals what emotional ways we conventionally take for granted . . . the emotional rebel who does not feel as she should makes us marvel that rebellion is so rare (1975, p. 229).

The "different standard of truth and falseness of expression" which emerged in this instance meant that consumers/survivors frequently ignored the legislation subcommittee's explicit mandate and procedures. Instead, they used the public hearings to express the pain in their lives. They wanted a professional/bureaucratic response to the emotional as well as the cognitive aspects of their speaking out. The fact that they rarely received it was more than a breach of decorum.

CONCLUSION

Writing this article has been unexpectedly difficult. It caused me to remember the hope and enthusiasm, the (relative) innocence with which the CMHA National began to advocate for consumer participation. It tossed up poignant memories of Ontario's consultation on community mental health services legislation, memories which recalled the unfolding human complexity of consumer participation as lived experience, as lived policy making. Finally, it touched off the despair I feel today as I perceive both new and renewed barriers to (all kinds of) participation created by economic restructuring and government cutbacks. In the face of this enormous challenge, community mental health practitioners must not forget one of the biggest lessons we have learned about "consumer participation" so far. Beyond "representation," this is a process which requires what Worsham refers to as a "fundamental re-education of emotion." At some point, we must acknowledge that the "emotional constitution" of our divisions within the mental health field ". . . holds sway so deeply that it retains an immunity to the legislative efforts of social critique and to the legislative gains of progressive social movements" (Worsham, 1992-1993, p. 122).

Between mental health professionals/bureaucrats and psychiatric consumers/survivors, there is no such thing as simple rudeness. Rudeness is a socially constructed phenomenon which has class, gender, racial, and—as in this instance—other dimensions. The consultation on community mental health services legislation was a mobile drama on this theme. Professionals/bureaucrats and consumers/survivors operated throughout that process from very different behavioural codes. The pivotal issue, acted out indirectly in all kinds of interactions, was whether and how deeply to include personal experience and emotions as forms of knowledge. Survivors actively attempted to supplant the dominant professional code of "reasonable" behaviour, a code based on objectivity, with a code which included—but was not limited to—subjectivity. The struggle over "bad manners" was about whether they could become powerful in establishing different definitions of rationality by which to transform and to govern the mental health system.

NOTES

1. I have used the term "consumer participation" because it was the phrase in use when the policy was established. My term of choice is "survivor participation." Likewise, when the

CMHA first began to do this work, "consumer" was the leading edge term being used to challenge the use of "mentally ill" or "psychiatrically disabled." In 1990, I used the term "consumer/survivor" in the TPS brief to the legislation subcommittee. It was intended to reflect the language disputes which were ongoing among users of mental health services at the time; its use has since become prevalent. The term "psychiatric survivor" was introduced to Canada in 1989 by British survivors who attended "Our Turn," the first independent national conference of mental health service users in this country. It caught on and is now widely used. In fact, all of these terms are in use to some degree depending on the politics of the people involved. This makes both speaking and writing tricky, to say the least. Unless I am writing for a group which has distinct preferences, I invariably alternate between "consumer/survivor" and "psychiatric survivor" in my written work. Although I find "consumer" unsatisfactory for a variety of reasons, I sometimes include it because I recognize that some people in the movement prefer it. In conversation I prefer to use "survivor," as do most of the people/groups with whom I currently work. These distinctions must be made to contextualize and facilitate the reading of this article. The use of words by academics who work with the psychiatric survivor movement must continually be examined.

2. Some clarification is also required around my use of the terms "mental health professional" and "bureaucrat." I use "mental health professional" in a very broad sense to refer to individuals who were involved with the legislation subcommittee as paid participants (i.e., service providers, government employees, or consultants). They may or may not have specific training in mental health issues. I use the term "bureaucrat" in a very specific sense to refer to the individuals whose involvement with the committee was as paid staff either in the Community Mental Health Branch or in other parts of the Ministry of Health. I use the term "professional/bureaucrat" to signify that both groups share a perspective which is based on "objective" expertise rather than personal experience.
3. The terms of reference for the provincial steering committee appointed to oversee implementation of the Graham Report are as follows:
 - To co-ordinate the work of the subcommittees to ensure consistency with Ministry of Health directions;
 - To deal with outstanding issues from each of the subcommittees which require decisions at a senior level;
 - To update and advise senior management of the Ministry of Health on the progress of the work of the subcommittees;
 - To provide advice to the subcommittees as required;
 - To liaise as needed with other ministries and such bodies as the Premier's Council on Health Strategy.

The terms of reference for the Implementation Strategy Subcommittee are as follows:

 - To provide a formal orientation to the Report of the Provincial Community Mental Health Committee and ongoing technical assistance in planning and developing mental health services for District Health Councils;
 - To provide advice to the Ministry of Community Mental Health Program proposals submitted by District Health Councils to the Ministry for fiscal years 1989/90 and 1990/91;
 - To develop guidelines for long-range planning of mental health services, in keeping with developing community mental health legislation, for approval by the Ministry of Health and distribution to District Health Councils;
 - To provide advice to the Ministry on program proposals and plans developed by provincial psychiatric hospitals as part of the District Health Council process;
 - To develop a short-term funding strategy for fiscal years 1989/90 and 1990/91 and a long-range funding strategy for mental health services in relation to other priorities for the fiscal period of 1991 and 1992;
 - To act on other recommendations of the Report of the Provincial Community Mental Health Committee as deemed appropriate.

The terms of reference for the Legislation Subcommittee are as follows:

- Provide advice to the Ministry of Health regarding the purpose and scope of community mental health legislation;
 - Assist the Ministry of Health to define and conduct a consultation process with major interest groups;
 - Review input received through the consultations and advise the Ministry of Health on issues and concerns raised;
 - Assist the Ministry of Health to develop draft legislation;
 - Provide advice on other matters as requested by the Steering Committee.
4. The 14 questions from the legislation subcommittee's consultation document are as follows:
- What should be the scope of the legislation?
 - How should consumers, family, and community members be involved in planning, co-ordination, and delivery of mental health services?
 - Should the system for planning, administering, delivering, and evaluating mental health services be centralized or decentralized?
 - What should be the geographical unit of a regional system?
 - If it were to be decentralized, how should a regional mental health/community services authority be structured?
 - What mandate should be given to a regional mental health/community services authority?
 - How should a regional mental health/community services authority be financed?
 - Should the legislation guarantee the right to receive services?
 - How should services for individuals with a serious or prolonged mental illness or impairment be coordinated?
 - How should the principles and functions of a coordinated mental health services system be incorporated into the legislation?
 - Should the legislation include a mechanism for quality control for standards of care and programs? If so, how should they be enforced?
 - What provisions should there be for record keeping and confidentiality of and access to records?
 - Should the legislation include provisions for out-patient commitment/compulsory community treatment?
 - How should the legislation deal with the issues of incompetency and substitute consent?

RÉSUMÉ

Cet article commente le travail du sous-comité législatif du comité d'organisation responsable de la mise en oeuvre du Rapport Graham. Ce rapport décrit le schéma directeur pour la planification de la santé mentale communautaire en Ontario. Le commentaire porte sur les obstacles à la participation des «psychiatrisés(es)» à la consultation provinciale de 1990 du sous-comité, y compris la stigmatisation des actions des «psychiatrisés(es)» durant l'événement, celles-ci étant perçues comme des «mauvaises manières». L'auteure considère que cette appellation est un geste d'appropriation du pouvoir. Des conflits sont survenus parce que les deux groupes s'inspiraient de codes comportementaux divergents. L'enjeu principal était de savoir s'il fallait inclure l'expérience personnelle et les émotions comme des formes de connaissance. Les dimensions culturelles de la «participation du consommateur» doivent être davantage reconnues et prises en compte si on souhaite que cette politique demeure viable, surtout en ces temps de restructuration économique.

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