

Like Minds: Peer Support Education – a model of empowerment education

A. Background and Context:

Mental illness comprises a spectrum of disorders and conditions that effect mood, thinking and behaviour. These disorders can be severe and persistent, requiring comprehensive and continuous intervention and support, or they can be episodic and less intrusive on a person's function and quality of life. Typical interventions to treat mental illness include medications as well as a variety of verbal and activity-oriented interventions, in either individual or group contexts. Mental illness effects one in every five people (Kirby, 2004) but stigma precludes disclosure, so the incidence is generally considered to be higher than reported.

Stigma, results from a history of *madness* as a moral weakness and a condition that negatively affects rationality. Similarly, misrepresentation of people with mental illness as dangerous (Harris and Rice, 1997) has influenced the public and legislators to not only apply restrictions against the liberty of people with mental illness but also to have turned a blind eye to abuses and discrimination (Everett, 2000). A culture of shame, failure and hopelessness has prevailed that has been both intentionally and unintentionally sustained by the mental health system, those who provide services, and the general conditions of society that are encountered in social communities.

Social and material conditions (Durkeim, 1951), which includes but is not limited to stigma, pre-fix the capacity of people with mental illness to access knowledge about, as well as participation in, their service system. Durkheim's concept of *anomie* intends awareness and knowledge of these conditions of socialization, including power. *Anomie* is exposed in transitions of role, regulation and expectation. With transition, "[t]he [social] scale is upset; [and] a new scale cannot be immediately improvised" (Durkheim, 1951, p253). Improvising against the upset social scale is difficult at the best of times; it is especially difficult for people also affected by mental illness who are impacted by a tradition of social perception that disadvantages their foothold for both personal and power and determination regarding the services they receive. Education supports the journey of transition, a transition of awareness and empowerment, and this paper will review one such educational program, *Like Minds: Peer Support Education*.

Self awareness is a point of transition of knowledge toward self determination and is both a function of *anomie* and a requirement of empowerment. Despite recent proposals to advance *client-centred care*, mental health services are typically structured on a medical and illness-based model of etiology and intervention that places people with mental illness in a subordinate position within the hierarchy of power. People with mental illness are the *cared for*, the *helped*, which is interpreted as people who are less capable, perhaps even less worthy of consultation, inclusion and certainly self determination. Although not a new idea, resurgence in a philosophy of *recovery* seeks to redefine the mental health system, equalize the balance of power and support meaningful contributions of people with mental illness as providers of service as well as leaders in system design and development. Recovery supports the journey of transition that improvises a new social scale, or transformation.

Shifting the balance of power from the people who hold professional and positional power to people with mental illness is not a simple conclusion to the problem of correcting the hierarchy. The problematic (Smith, 1984) that underlies this proposal assumes that power is a commodity that can be functionally transferred from those with it to those without it; that the powerful *empower* the powerless. Rather, a preferred concept is that of *empowerment* which builds and improvises power from within the experience of people with mental illness by addressing knowledge and skill through education (hooks, 1994). Empowerment realigns power in a transitive way from a hierarchy of *carers* and *cared for*, to a matrix of equal and interdependent partners in influence and action.

In my personal and professional experience with mental illness I have been a *carer*, a *cared for*, a peer and a partner. My experience has exposed me to the devastating, debilitating, humiliating effects of mental illness, as well as the generative effect that emerges from vulnerability. I have been party to, witnessed and personally experienced the discrepancy of power and influence between people who have experienced mental illness and those who *care for* them. The playing field in terms of receiving service, contributing to service and influencing service leadership is not equal. To this end, from the standpoint of a mental health system clinician and leader, with personal experience with mental illness, I am engaged to transform the landscape and structure of power in mental health services to a structure of empowerment and interdependency.

The central element in transformation is to change the balance of power – reestablishing the power of people who experience mental illness and balancing it with the power held by those who plan, deliver and evaluate mental health services. Reestablishing the balance of power requires critical interrogation and a process of knowing power rather than a dismissal of existing structures (hooks, 1994). Barker (1998) reviews power, from the perspective advanced by Foucault, as a term to describe a broad and generalized series of strategic relations that coexists in society and delineate conditions of domination and resistance. Barker reiterates Foucault's position that power is pervasive and so clearly linked to knowledge that "any attempt to isolate power from knowledge is likely to lead to an inadequate analysis of its operation" (Baker, 1998, pg 27). Therefore, education leverages a critique of power where it intersects with knowledge to affect transformation.

Transformation, particularly the radical, operational shift in knowledge and power that positions people who have survived mental illness as interdependent partners with the people who have diagnosed and who treat them requires a framework of debate and engagement. First, fulsome debate is required regarding the intersections of power related to the fundamental language and intention related to illness versus wellness, and helper or carer versus partner. This debate must expose the scope and impact of the power structures and relationships between the two groups, including the need for inclusion and voice. Finally, to realize engagement, knowledge integration strategies to develop, support and embed the theory of recovery and empowerment are needed to disarm and dismantle existing relations of intentional and unintentional domination and resistance.

B. The Problem:

As a provider of mental health services, I know that in my actions I have perpetuated discretions of power, both intentionally and unintentionally, simply as a result of my position. As a person with mental illness, I have resisted the power of providers, mostly intentionally but also unintentionally. I appreciate that resistance to my *care for* people with

mental illness has been equally resisted with or without my awareness. A transformed set of relationships in mental health service must deviate from the accepted concept of *care* or *helping*, which implies an imbalance of power and self-determination, and rebuild the knowledge base as a platform of equity, empowerment and interdependence, before a commitment to wellness and recovery can be realized.

The status of specialized, credentialed, mainstream mental health services, such as medicine, nursing, social work and psychology, have been recognized as an interdependent professional unit providing mental health services. However, real interdependence requires that people who have experienced mental illness either personally or as a family member are recognized as an equal component of that unit, as legitimate contributors to a system of service that augments and compliments the traditional treatments and thereby approximates a complete and holistic network of treatment and support.

The advocacy movement that represents people with mental illness is known as *Consumerism* (Tosh, Ralph & Campbell, 2000), and its history clearly develops the principles of humane, or least intrusive treatment, self determination and empowerment. While these principles have been operationalized in part through legislated models of consultation, and membership criteria, for boards and committees that require representation by people who have experienced mental illness (Valentine, 1989), the full impact of the power matrix has not been fully addressed. For instance, autonomous organizations that are directly led and operated by people who have experienced mental illness are underfunded and underutilized as consultative partners or legitimate service partners. (Ontario Peer Development Initiative, 2006).

In terms of system leadership, Valentine (1989) is clear in her review of the issues of committee and board representation by people who have experienced mental illness that: “To accept pluralism is to acknowledge that there is more than one ultimate principle or perspective to be considered – that different values, views and interests should be brought to bear when decisions are made.....people should be represented in the decisions that concern them.”. Intuitively, this premise holds both logic and promise; however, the structures and relationships of power limit the capacity for equitable engagement for people who, as Valentine states, are concerned by the decisions. Building on Foucault’s premise that binds knowledge and power as a matrix that sustains systems such as the mental health service system, engaging and operating changes to knowledge will shift power.

People who live with mental illness encounter structures and relationships of power that essentially exclude them from participating in the planning, delivery and evaluation services relevant to their recovery. Negotiating this complex historical, institutional and social power matrix requires a self-awareness and social literacy that people with mental illness have difficulty accessing. The people who are used to making independent decisions and being in control of clinical services, who are comfortable and competent at committee meetings and who are articulate and speak the recognizable language of power and position, can drown out those who have as much to contribute but who do not feel welcomed or confident in doing so. Provincial educational programs designed to orient and train people with mental illness regarding governance models and function, so they can participate as members of boards of directors with comfort and confidence are no longer funded (Ontario Peer Development Initiative, 2006).

Initiating engagement with respect to shifting the matrix of knowledge and power requires substantial sensitivity. Expecting wholesale and honest participation in discussion

regarding services that may not have met expectations, amongst people who may be future *caregivers* may be perceived as too dangerous for people with mental illness. Not only does skill and comfort restrict the willingness of people with mental illness to shake the tree of traditional power, but as Everett (2000) suggests: to challenge both the “rational scientific truth” and “higher authority of doing good” is obviously daunting. The observation by Nabokov from his novel *Bending Sinister*, and resurrected by Nafisi (2004) is particularly apt for people with mental illness who challenge authority: “curiosity is insubordination in its simplest form”. The problem is looming.

C. Addressing the Problem:

Given the description of the problem which is developed above and using the matrix of knowledge and power as both the restrictive element that sustains docility and obedience of *patients* in their traditional role as well as a tool to transform and challenge the structures and relationships that sustain this perception, a strategy that engages and educates people with mental illness about recovery, empowerment and service partnership has been developed and the impact of this program has been reviewed. Using a participatory process, led by people with mental illness, an educational program has been designed and delivered to advance the shift in traditional power imbalance and to develop the capacity to identify, question, challenge and uses knowledge to dismantle the accepted matrix of power.

Like Minds: Peer Support Education is a comprehensive educational program developed to educate people who live with mental illness to be leaders and providers of mental health service and support. People with mental illness are peer educators who re-centre knowledge regarding capacity and legitimacy as role models who have successfully risked system critique and been rewarded. *Like Minds: Peer Support Education* is grounded in a theoretical model of recovery (Copeland, 2004; Mead and Copeland, 2000) that values: critique of power; oppression and discrimination, as well as a model of meaningful and generative engagement that Freire (1999) has described as *conscientization*, or a process of raising awareness, appreciation and the energy for transformation. Small, interactive, groups of people with mental illness, engage in peer facilitated dialogue and exchange of experience, ideas and questions demonstrating “engaged pedagogy” as described by bell hooks (1994).

Consistent to the assumption that knowledge binds power in a matrix of domination and resistance, knowledge therefore operates social action, and shifts in power. “Knowledge has to be unearthed in each individual, [then] collectively reformulated, and analyzed, so that it can be applied in collective actions to benefit a group or community” (Selner 1998, p. 25). This process described by Selner reiterates the concept *conscientization* as articulated by Freire (1999). Collaborative inquiry and reflection brings to light a person’s awareness of their own resources, and mobilize self-determination; therefore inquiry, or critique, and reflection are essential attributes to realize *em-powerment*. The underlying assumption that knowledge is essential to change obviates the link between power and education, and pins it to transition and transformation. Transforming requires *being* critical (Hinchey, 2001; McLaren and Giarelli, 1995). Being critical underpins the process of discovery and understanding as well as reconsidering and resisting obedience. Becoming critical requires Nabokov’s leap of curiosity and *insubordination*. Being critical includes not only a reflection or examination of the problem –but it clearly requires firm appreciation of the history of the subject as well as the previously held and accepted knowledge related to the subject, and the people connected with the subject (Hart, 1998).

D. Additional Conceptual Underpinnings:

Transforming systems of power is not an easy process; it cannot be implemented by applying a set of objectives or activities. Transformation requires critical engagement to review and challenge accepted and established beliefs, practices and structures. Critical theory challenges the basic structure of society, especially the structures which generate and sustain the factors that marginalize people (Hinchey, 2001; McLaren & Giarelli, 1995) – in this case people who have experienced mental illness are seeking to transform the matrix of power and knowledge in the mental health service system. The process of critical thinking requires an examination of underlying assumptions and contexts, discarding inappropriate assumptions and exploring alternatives to thinking and living (Brookfield, 1987). The development of critical thinking requires reflection, challenging of the status quo and a tolerance to the ambiguity and uncertainty of analysis and argument (Brookfield, 1987). The requirements for critical thinking are risky for people who often rely on the people they wish to challenge for their treatment, and in some cases for their liberty.

Similarly, critique is facilitated by interaction, or participation in debate and dialogue. Participation is a dialectical process that requires people are included as a partner in dialogue. It includes both interaction and reflection. It values common, popular or indigenous knowledge as fundamental to understanding and assigning meaning to experience, and the prescription of problem resolution. (Hall, 1981; Hall, 1975; Selener, 1998; Schram, 2003). Reflective participation both requires and creates a space and opportunity to openly consider not only current practice and belief but also to consider and propose alternative practices and beliefs. Freire's (1999) process of conscientization acknowledges the instructive and liberating effects of participation. While building previous and current knowledge and experience, it is also essential to awakening the critical mind – a questioning and observant mind (Hinchey, 2001; McLaren and Giarelli, 1995; Brookfield, 1987; Freire, 1999). Critical challenge and transformation of system and social structures is the focus of critical theory.

E. Developing the Like Minds: Peer Support Education program:

Three key areas of theory must be understood to appreciate and advance the design and development of a program for empowerment education such as Like Minds: Peer Support Education. The first area of consideration relates to the theories of interpersonal and systemic power and influence. Integral to understanding these effects of power is an appreciation of the underlying dynamics of: helpers and the helped; domination, or oppression, and resistance; and marginalization and discrimination. Psychiatric structures of discipline and surveillance, as explained by Foucault (1980), factor greatly in adjusting prior power based relationships to ones of shared responsibility; the capacity to mitigate and correct this history will affect the degree of transition realized by people with mental illness from recipients of service to service providers and decision-makers.

Similarly, theories of empowerment and liberation, as posed by Freire (1989), propose corrective strategies that support engagement and self determination. As noted above in terms of transition and transformation, theories of critical thinking are also essential to full examination and evaluation of the issues and dynamics that exist when there are differences in power. These questions focus the critique of power: who stands to gain from maintaining the status quo; who drives the process; and who is included and heard. Power must be understood in order to propose change. "Power is simply the effectiveness of strategies for

achieving for oneself a greater scope for action than others implicated by one's strategies" (Clegg, 1989, p. 32); or, power is action, outcome and benefit. Foucault (1980) suggests that in the act of controlling formal institutional structures, such as who receives mental health service, where and when service is provided and who is consulted and involved in service, medical authorities articulate the commodity of power.

When some members of the group partially or totally cede power, it enables political power or sovereignty to be established and sustained by other, elite members of the group. Bylaws and rules of order for Boards or committees represent *discipline* which is designed to assure consistency and assign prescribed outcomes which generally focus on efficiency, often at the expense of effectiveness (Gross Stein, 2001) and from the perspective of the leader representing others who have experienced mental illness, may be experienced as a compromise that advances but does not complete and improve the outcome, or as a *sell out* to their peers. Therefore, for the reasons described above, education designed to improve knowledge and power literacy to adjust and transform structures of power must insist on transparent debate regarding the relationships, processes and artifacts of power that exist in mental health service, including the factors that limit or constrain critical engagement by people with mental illness.

The second area of theoretical consideration is related to power but is specific to decision-making. That is, during the decision-making process, how does power exhibited by those with positional or personal power tilt the balance in their favour? The tilted balance of power includes discrepancies of power related to specific matters as well as agenda setting. Elite individuals or groups, as a result of their positional power, are instrumental in identifying operational values, issues and accountabilities. Therefore, in addition to holding more decision-making influence, they also set the decision-making agenda by determining the relevance of issues eligible for discussion and decision-making (Townsend, 1998; Starratt, 2003).

People who have experienced mental illness have been required to trust and subordinate to the processes that decide about and deliver service to them without curiosity or question; they are the *cared for – the helped*. Without regular and consistent access to the power structure, and legitimate decision-making process, people who have experienced mental illness are also prevented from shaping the values which define services they receive. Without full access to meaningful contribution, their acceptance of decisions is limited and resistance is bred. This creates a pernicious factor that further isolates people who have experienced mental illness, who assume a leadership role, from engaging in an open and genuine dialogue with identified elite leaders.

Therefore, to be effective in terms of educating to examine and explore the dynamics of contribution and participation, the program curriculum must include theoretical and practical consideration regarding how clinical and systemic decisions are made. Essential questions include: what are the factors that support or restrain participation in decision-making; how do decision making structures, agreement and processes include or exclude consensus or democratic process; what mitigates the influence of elite individuals or groups? What knowledge and experience do people with mental illness need to infiltrate, influence and transform decision-making?

The third area for theoretical consideration also relates to power and empowerment but is more specific to the process of personal change. Exploring the structures that disable participation and identifying the structures that advance participation expose the underbelly

of traditional power structures and frameworks. Toppling faith in experts, as a factor in obedience, challenges singular hegemony and establishes a pluralistic and transformative base for organizations to realize the knowledge capacity within it. Leveraging the perspective of knowledge affects the relation of power in the knowledge-power matrix.

Using a framework of critique presented by Foucault (1980, 1988), which asserts the importance of apprehending fully the operation of domination and resistance, or the systems of constraint and control, as well as by asking critical questions, and especially by listening to the answers, an initial understanding of participation in mental health decision-making structures can be formed. Collaborative questioning and challenges to process that are not only free of reprisal, but more particularly welcomed and embraced, form a deeper approach to participation. Therefore, empowering education must include strategies to effectively reducing the risk for people who have experienced mental illness, to be curious and insubordinate, to question, to assume leadership roles and therefore to contribute to actively evaluating and managing the mental health system. A curriculum that increases theoretical knowledge regarding process and structure as well as building and improving skills related to reflective awareness, assertiveness and productive argumentation supports the transfer of legitimacy from an authority to oneself.

F. Program Design and Delivery:

Like Minds: Peer Support Education is a comprehensive course designed by people with mental illness and delivered by them to their peers. The design creates a space for learning that promotes curiosity, critique, discussion and debate. Peer educators, in their legitimate role facilitating knowledge exchange, assign the hope essential in a culture of recovery. While the stated intent of the program is to provide training in Peer Support, which employs people who have personal experience with mental illness to be supports and mentors to others with similar experience, the content also addresses knowledge and skill required for system leadership. Consistent with the conceptual underpinnings and theoretical assumptions described above, *Like Minds: Peer Support Education* articulates an approach to service that is based in *recovery* rather than the traditional medical model of illness and symptom management.

Recovery, according to Mary Ellen Copeland (2004) and Shery Mead (Mead and Copeland, 2000), pioneers in this theoretical model, asserts the following four values: 1) a vision of *hope* that includes no limits; 2) *self determination* and personal responsibility for one's own wellness including advocating for what one needs, wants and deserves; 3) *education* to support people to take the positive risks needed to learn and grow; and 4) *partnership* and mutual relationships. Using these four values as a platform for learning, the *Like Minds* program facilitated the development of knowledge and skill required to support the transition of becoming a Peer Supporter and to support further engagement with the mental health service system.

Like Minds: Peer Support Education was designed in a modular format so it could be delivered in a variety of schedules. Existing literature about peer support training was reviewed, mainstream partners were consulted to provide their advice about training needs and an existing peer education program adapted some of their existing educational programs to meet the requirements of this specific peer support education program. Embedded in the program is a strong Aboriginal orientation and specific First Nations teachings that supports existing service relationships and commitments for our geographical area. The program

represented in this evaluation comprised two series of three-day workshops as well as one follow up session where participants were invited to reconvene to review their challenges, struggles and accomplishments in the field. Seven peer educators were financed through a Trillium Grant to develop the curriculum and plan their delivery strategies. Grant funding also permitted free access to the program for participants as well as offsetting expenses related to travel to the program.

The content of Like Minds: Peer Support Education addresses the pervasive power imbalances inherent to being a recipient of service as well as related to employment as a service partner or leader. Dialogue is facilitated regarding the legitimacy of expertise related to experience rather expertise related to a professional credential. The curriculum considers the often subtle but significant differences between peer support and mainstream mental health and addiction services, and how these two areas of services can become interdependent. Recovery, by definition considers of a number of questions including: who's the expert; what is the intention or purpose of the relationship; what is legitimacy; what are acceptable outcomes? Ongoing discussion supports debate about the issues of power and equality, and oppression and discrimination.

Keeping in mind the important relationship Foucault proposes between knowledge and power, each module of Like Minds: Peer Support Education is intended to provide background knowledge and build understanding about the role and value of peers in recovery and leadership. The program included the following content: orientation to, and education about, the philosophy and background of peer support; issues related to role adjustment and transition; as well as relationship skills such as communication; conflict management, facilitation; motivation and crisis intervention. Education regarding personal skills included: self care; boundaries; and organization and time management. One module of the curriculum is designed to increase knowledge of the technical language and treatment perspective of mainstream partners.

G. Program Evaluation and Impact:

Two full programs and one consolidated follow up session were delivered to 44 peers as a pilot project in March 2006. A comprehensive evaluation was conducted. Participants reported that they attended because they were interested in becoming peer supporters; participants who were peer supporters reported that they attended to enhance their current skills and knowledge and to feel more comfortable in their current job. Participants represented many kinds of peer support; many participants performed more than one kind of peer support. Nearly half (45%) of the participants worked in mainstream teams; 30% of participants provided peer support in mainstream drop ins and 15% provided peer support as embedded members of mainstream service teams, such as an Assertive Community Treatment Team. Membership on boards of directors was another way peers supported peers: 23% of participants identified that they were members of mainstream boards of directors or committees and 15% were members of a consumer-run boards of directors or committees. Slightly fewer participants worked in initiatives operated by people with mental illness, or peer run programs: 30% provided peer support in a peer run organization and 8% provided peer support with a peer-run service team. A further 23% of participants provided peer support as friendly visitors in either a mainstream or a consumer run program. This diversity supported our philosophy of inclusion and broad scope of the curriculum.

The follow up session was attended by 16 participants. Of those who attended the follow up session 81% were currently providing peer support and half of those participants were employed in paid positions. The evaluation of program effectiveness and utility indicated that the content met or exceeded participant expectation, it was well delivered and participants learned new knowledge and skills. The follow up session feedback results indicated that participants found the program overwhelming and intense and would prefer that the modules were separated by a few days in order to absorb the volume and complexity of the information.

Impact evaluation indicated that 100% of participants reported a better understanding of peer support after attending the program and 85% of participants currently providing peer support reported feeling more confident in their role after attending the program. 62% of the participants reported that they have a better understanding of how peer support integrates with mainstream services and 69% of participant's currently providing peer support reported that they place higher value on their role after attending the program. In terms of developing knowledge and skills, 77% of participants currently providing peer support reported they now have more knowledge to do their work and 69% of participants currently providing peer support reported they have more skills now to do their work.

The impact evaluation further revealed that participants particularly appreciated the opportunity to discuss, consider and reflect about the philosophy of peer support. These conversations opened the door for participants to express their frustration with mainstream attitudes and behaviours. The evaluation recommends that the mainstream be informed and educated about recovery and the role and function of peer support, especially the subtle but significant differences in service delivery and peer-to-peer relationships. Participants expressed concern that peer support not be perceived as "cheap mainstream work". Participants agreed to the importance of establishing peer support as its own distinct approach to service; they insisted that the hierarchy must be addressed.

Moreover, participants clearly articulated their struggles with the imbalance of power. They proposed solutions and expressed a commitment to remain personally engaged in future debates. They suggested that it would be particularly effective for peers to provide recovery orientation, clarify and correct errors in perspective if they were seen as, or felt they were equal members of the team. In so doing, mainstream clinical and system power-brokers will see the value, credibility, and legitimacy of peer support as an equal component and partner in service. Finally, participants engaged in a passionate debate regarding their experience of discrimination and stigma embedded in the system at a high level. Participants identified the need for radical change to beliefs and attitude, as well as radical change to the mental health and addiction infrastructure and system, including a commitment to have peer support and peer leadership work valued with fair remuneration.

Participants also identified changes in their personal awareness and growth during the reflective process, especially during the follow up session that contributed to the impact evaluation. Peers articulated that if you work in the mainstream, the service you provide is your career, or job; peers said that the role is their life - the "hat" doesn't come off. In this regard, peer supporters feel that it is not "safe" to have a "bad day" without raising concern with their mainstream partners. Participants also identified a need for peers to develop confidence, assertiveness and leadership skills. In terms of accomplishments, participants report a sense of personal empowerment and confidence to take the next step in terms of their role of peer supporter. Participants indicated that they have used their new knowledge to take

advantage of opportunities and more are employed since the program. They also report a better understanding of the concept of interdependence.

Finally, the consensus of participants and educators is clearly that the program was successful in terms of providing education, confirming peer support as a valuable component of service, and supporting debate regarding peer support and interdependent partnership in the mental health system. Participants indicated that after completing the program they have more knowledge, skill and comfort to support their role of peer supporter. The most profound challenge reported by participants was negotiating a working relationship with people providing mainstream services. In particular, they identified discrepancies of power specific to being accepted, being valued and having peer support legitimately recognized as a specialty service.

Participants report that the program raised awareness related to empowerment. The evaluation concludes that education leads to increased interest in and capacity to address imbalances in power and supports personal empowerment. Peer educators reflected on their experience and determined that the program supported their personal empowerment. Like Minds: Peer Support Education was experienced by all its participants as an effective educational strategy that raised awareness, and provided a framework to debate and advocate a shift to the balance of power from those who typically hold power to those who have typically been perceived as less capable and therefore less engaged.

H. Conclusions:

Despite what I choose to identify as primarily good intentions, the mental health system has perpetuated a hierarchy of power that places recipients of service in a subordinate position that excludes them meaningful participation in service planning and delivery. A theoretical perspective of illness and deficit has supported the belief that people with mental illness are neither capable of nor willing to engage in critique of the system. More importantly, challenging the hierarchies of power bears risks for people with mental illness who may wish to challenge structures and relationships that are too great to safely consider. Consumerism, the advocacy movement that emerged from within the ranks of people with mental illness, has countered the prevailing attitude and increasing acceptance of a theoretical perspective of recovery insists on increasing participation, awareness, engagement and finally equity and empowerment.

Like Minds: Peer Support Education operates an engaged pedagogy that opens a safe and nurturing space where knowledge exchange and acquisition can expose the seat of power and unbind the matrix that sustains both the structure and relationships of power as well as spark and support generative dialogue and debate to reframe and decentre current and accepted power structures. Participants describe their experience in the Like Minds program as empowering; it increased their knowledge, skill, awareness and comfort with respect to their interrelationship with the mental health system as a distinct agent of recovery.

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