CONSUMERS *as* PROVIDERS *in* PSYCHIATRIC REHABILITATION

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Chapter 6

Peer Support for People Challenged by Dual Diagnosis: "Helpful People in Touch"

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People with dual/multiple diagnoses of mental illness, drug addiction and alcoholism experience the same severity of symptoms from substance disorders as do people who have alcohol and drug dependence but are not severely mentally ill. People who face these disorders and the issues they create often require daily support groups and networks at various stages of recovery. For some, on-going support may be necessary for years. Self-help support programs for people with dual disorders are very effective adjuncts to formal treatment. Such programs help participants attain and maintain recovery from substance abuse and addiction. The consumers who have developed and maintained the program, "Helpful People in Touch," have demonstrated that their programs are effective and beneficial for themselves and for their peers. As a result, they have provided a self-help program that was previously absent from both the mental health and substance abuse systems.

The development of treatment models and treatment programs for people with dual/multiple disorders (Sciacca,1987), has demonstrated that new and special program models are necessary. Correcting services that lack treatment resources for people with dual diagnoses requires a comprehensive approach, integrating mental health and addiction treatment into a single program design (Sciacca,1991). Traditional self-help programs have evolved to address singular, discrete disorders. Traditional twelve-step programs for alcoholism and drug dependence often neglect to address severe mental illness. People who have a severe mental illness often attempt to conceal this when attending such programs. Therefore, a self-help model that included all aspects of a person's symptoms and needs was developed. This program, "Helpful People in Touch," was developed by the participants; therefore, the format and content express what is important to these consumers within the realm of self-help.

This article begins with an overview of the profiles of people who participate in special MICAA (Mentally Ill Chemical Abusers Addicted) programs, in contrast to the profiles of people who participate in traditional addiction treatment services and self-help groups. Some aspects of traditional twelve-step programs will be reviewed, followed by a detailed outline of the development of the consumer-led program "Helpful People in Touch."

Description of Consumer Profiles

The term "Mentally Ill Chemical Abusers and Addicted" or MICAA was introduced by the New York State Commission on Quality of Care (1986). The

Commission's report clearly suggested the acronym MICAA to denote people who had a severe, persistent mental illness that exists independent of, yet is co-occurring with, chemical abuse and/or addiction. Characteristics associated with the MICAA label (Sciacca,1991) include the use of prescribed medication to control symptoms of mental illness; and substance abuse which exacerbates acute psychiatric symptoms and/or diminishes the effectiveness of medication. People who have MICAA generally access services in mental health programs. This term is in contrast to "Chemical Abusing Mentally Ill (CAMI)," which denotes people who have alcohol and/or drug dependence with co-occurring personality disorders (Axis 11, DSM-111) (Solomon, 1982), but do not have a severe mental illness.

The program described in this chapter is designed specifically for people with MICAA, not for people who are CAMI. People who are CAMI are most often appropriate for participation in traditional twelve-step self-help programs.

Traditional Twelve-Step Self-Help Recovery Programs

Traditional self-help programs for alcoholism, such as Alcoholics Anonymous (A.A.), are guided by twelve steps suggested as a program of recovery (A.A.,1976). Subsequent programs for drug addiction have also been developed around these steps and traditions, for example, Narcotics Anonymous (N.A.). The fourth step or tradition that guides A.A. espouses that "Each group should be autonomous except in matters affecting other groups or A.A. as a whole." For this reason, the composition of different groups may be more or less compatible with severe mental illness. For example, although A.A. literature clearly states that prescribed medication is strictly a matter between the participant and his/her physician, some A.A. groups include members who believe in abstinence from all chemicals, prescribed or not. When recommending A.A. meetings to people who take prescribed medication, it is important to advise them that some A.A. members may have such beliefs and, if possible, to locate groups where participants do not hold them.

One traditional A.A. concept that is adverse for MICAA consumers is that of "hitting bottom." In other words, participants must experience severe losses or deterioration in order to perceive that they need help for their addictions. This is not recommended for people who have a severe psychotic illness. Such deterioration is more often a traumatic experience that results in major setbacks in all areas of the person's functioning and stability. A MICAA consumer is best maintained at his/her level of stability, and increments of progress in substance abuse treatment should proceed from that level (Sciacca, 1987,1991).

An alternative to attending A.A. meetings in the community is the development of "institutional meetings." Institutional meetings are held in a variety of mental health settings, and led by an outside A.A. member. They are attended exclusively by consumers at the mental health facility. The success of these meetings depends upon the ability of the leader to modify A.A. steps and traditions and adapt the program to the needs of the participants.

Helpful People in Touch — A Consumer Self-Help Program for People Who Have a Severe Mental Illness and a Substance Disorder

In the treatment model for MICAA, the inclusion of A.A. guest speakers (Sciacca, 1987,1991) who visit groups and tell their stories and answer questions about twelve-step programs, serves as an introduction to A.A.This also serves to educate consumers about treatment approaches for substance disorders. Consumers with a severe mental illness who attend these programs must have an opportunity to discuss their positive and negative experiences with twelve-step programs in a setting that is accepting of all of their symptoms. In some instances, adjustments in one's participation will facilitate a beneficial involvement in a twelve-step program.

In recognition that traditional twelve-step programs are not always compatible or comprehensive for people who have a severe mental illness, the development of a self-help program to meet the needs of the participants was facilitated (Sciacca, 1991). This program was conceptualized to include participants community-wide versus institutional; therefore, it was open to all who wanted to attend.

MICAA program development for dual disorders yielded a community (in New York) where various hospitals, agencies, and community programs were addressing and/or providing treatment services for people with MICAA symptoms. Through the concept of interagency education and training that included consistent program materials and methods (Sciacca, 1990), numerous agencies appointed staff to participate and to develop program initiatives (Sciacca, 1987a). Programs included community residences, clinics, day treatment, shelters, hospital wards, continuing care programs, clubhouse programs, case management, addiction treatment programs, and others. These MICAA treatment programs differed from traditional substance abuse treatment in significant ways (Sciacca, 1991; Sciacca & Thompson,1996). In contrast to some traditional substance abuse programs that usually require consumers to be at treatment readiness that includes acknowledgement of a substance abuse problem and willingness to participate in treatment, MICAA programs began with consumers who were at various levels of readiness including denial of a substance abuse problem and lack of motivation or interest in treatment. Where traditional substance abuse treatment may include confrontational interventions to move consumers along the continuum of acceptance of substance disorders, MICAA treatment evolved with "non-confrontational" interventions in relationship to denial and readiness. MICAA consumers at various points of readiness and motivation along the continuum are free to explore education and information, give and receive support to group members, and decline to self disclose until they are comfortable doing so. This MICAA treatment philosophy readily transitioned into the development of the self-help program.

Discussion with consumers in the various MICAA programs about the potential usefulness of a new self-led, self-help model, produced enthusiastic responses. Consumers liked the idea of taking responsibility for running their own program including leading the groups. As a result, in the latter part of 1988, the plan to develop the program took shape.

An announcement of the intention to begin this program was sent to consumers, families and service providers. The notice clearly stated that the format, content, and philosophies of this program would be developed by the consumers in attendance. The meeting place was the MICAA Training Site, a New York State program which was directed and developed as a resource center for consumers, their families, and providers; other consumer groups such as MICAA-NON (Sciacca, Hatfield, 1995) were also held there. The training site served as a non-treatment oriented milieu. The role of the professional evolves from one of greater to lesser participation. A professional was in attendance throughout the planning stages, and then ceased to attend once the format was developed. The first meeting was held in January, 1989.

Structuring the Planning Meetings and Developing a Format

The meetings were scheduled in the evenings once a week, for one and one-half hours, since an assessment had found that support programs were most needed outside of treatment program hours.

The planning agenda, which took several meetings to cover, included the following:

1. Develop a *Statement of Purpose*: How should a MICAA self-help group be similar to or differ from traditional A.A., N.A.?
2. List *one goal*, activity: What would you like to get out of this group? What are the *common goals among participants*?
3. Determine how group members will *share the responsibility* for work.
4. List *tasks* that will help to achieve goals.
5. Develop *ground rules* for groups and participation.
6. Determine a *name for the group*.

The first meeting had five consumers in attendance. The consumers decided to limit the group size to twelve. A participant volunteered to write the responses on the board. A professional in attendance took the minutes. The group accomplished the statement of purpose and began to work on goals in the first meeting. Minutes were sent to the participants before the next meeting. They were also handed out to seven new participants at the second meeting.

The following are some excerpts from the summary of the first planning meeting:

"Everyone present agreed that the issues and areas they wanted to address were not limited to substance abuse issues. Therefore, this group would be open to any other concerns and issues."

Statement of Purpose. "This group was established to meet the needs of people who have a mental illness and some type of issue with the use of alcohol/drugs. It is meant to help people who have been unable to get help from

traditional self-help groups such as A.A. or N.A.. In many ways this group would discuss topics and issues that are unrelated to other self-help groups and substance abuse treatments."

The consumers identified certain aspects of traditional self-help groups that they wanted to include in their group. This included: refreshments, fellowship/support, willingness to actively participate, rotating leadership and other roles, a nice way of ending meetings, and learning about the twelve steps. The decision to use speakers, films and literature for education came out of the experiences some members had in MICAA treatment groups. They also outlined aspects of the A.A. program that they did not want to include: requirements about medications, about attending ninety meetings in ninety days, and about following the twelve steps.

A summary of the **goals** of each member included: open admission to anyone expressing an interest in learning about alcohol/drugs; being helpful to one another; improve communication and overcome inhibitions; learn about the experiences of others; explore one's own issues; and membership and participation in a group.

The second meeting opened with a review of the statement of purpose and goals. These ideas were explored and agreed upon by twelve consumers in attendance, including seven new participants. The group proceeded with discussing one **goal or activity** they personally would like to achieve. Their responses included: improve sobriety, quit smoking, improve mental health, gain clearer insight into drug cravings, learn coping mechanisms for illnesses, transition into the community, deal with stigma, improve self-confidence, and gain more independence.

The members outlined the tasks necessary to achieve their goals. It was agreed that **tasks would be shared and rotated**. An initial list of tasks was developed, and jobs were delegated for the next meeting.

In the third meeting members pared down **the tasks** to nine. The general job categories included: facilitating the meetings; shopping; setting up; cleaning; clerical work, and acquiring materials. Members also voted that two meetings would be the length of time for each position to be held. Leaders would choose the next person to perform the job from the next volunteer who had signed on to that particular job list. If a member did not feel comfortable performing a particular job alone, a "buddy" could accompany that member. A volunteer could sign her/his name to several job lists.

At the fourth meeting members established dues of one dollar per month from each participant for refreshments. They established the job of a treasurer to collect and account for dues. This job was to last for three months, and an assistant treasurer would replace him or her at the end of the appointment.

Item five on the agenda, **ground rules for group participation** was discussed. These included: participate in turn; stay on the topic; maintain touch with reality; exhibit self-control; share in job responsibilities; and refrain from physical violence. If anyone was to become violent for any reason, he or she would no longer be allowed to attend the group.

This was followed by establishing **rules for membership**. It was agreed that if a member missed three meetings, his or her membership would be evaluated for continued participation. Members were required to call if they were unable to attend. Members who did not pay their dues (unless they were in a financial crisis) were not to share in the refreshments.

The last item on the agenda, giving the **group a name**, was also accomplished at this meeting. The suggestion to combine ideas resulted in "Helpful People in Touch (Two Way Street)." As a result of all of the consumers' decisions, "Basic Guidelines for Facilitators" were developed to complement the purposes, goals, content and format of the meetings. Leaders relied upon these guidelines when conducting groups. The role of the leader included structuring participation of all members in discussions and decision making, and ensuring assignments and completion of each member's tasks. Near the close of each meeting, the members would decide the format and content of the next meeting. They would select from the use of reading materials, videos, a discussion topic, an invited speaker, or an open discussion. The decision to adopt "a nice way to end meetings" from the A.A. tradition (the serenity prayer), resulted in ending each meeting by reading aloud from *The Promise of a New Day: A Book of Daily Meditations* (Casey, 1983). The specific passage read was sent to all of the members with the minutes.

At the fifth meeting, co-facilitators were assigned for the next two meetings. The sixth meeting was consumer-led without a professional in attendance.

As agreed upon by both the consumers and training site staff, a staff member was on the premises during meetings (but did not attend the meetings). Staff were available to assist members with requests for materials, mailings, and to handle situations such as occasional attendance by an intoxicated individual.

Some of the ground rules emerged out of the concerns various members had about their ability to handle potential situations. These included behaviors deemed out of control or threatening such as intoxication or violence. Another concern was that of leading a group with a member or members who may be experiencing acute symptoms of their mental illness such as loss of touch with reality. For these and other reasons, the decision to have a staff member on the premises was mutually acceptable. Other ground rules such as speaking in turn, and staying on the topic, were addressed in the Guidelines for Facilitators. Group facilitators were responsible for assuring that each person has a turn to speak about topics, decisions, materials, or other group content. The guidelines also suggest that leaders keep participants on the topic, and bring them back when they have strayed from it.

Consumers took the responsibility of formulating this program very seriously. Each item on the agenda was carefully explored, and decision making included everyone in attendance. This responsibility carried over to the leadership and participation in the consumer led meetings. Consumers were concerned and supportive of one another. They participated in a candid manner and shared their own experiences generously. This led to trust and caring. For example, if a member was absent it was a matter of concern. They also concerned themselves

with outreach to new members, and assuring that others in need of their support group would find their way to it. Members encouraged one another to continue to work on their issues, and lent their insight to the matters presented by their peers. Members who led the meetings worked through their personal issues of shyness, self confidence, etc., and focused on the responsibilities of leadership.

Content of Meetings. The format and content of each meeting was agreed upon by members at the previous meeting. An educational meeting might include a video about alcoholism, drug addiction, mental illness, interaction effects of medications with various substances, treatment approaches, or a relevant movie. In dual disorder programs, learning about these topics always goes beyond the information presented to the exploration of the interactions between symptoms of substance disorders and symptoms of mental illness; and interactions between prescribed medications and illicit substances. Written materials might include fact sheets or articles about topics such as depression, cocaine addiction, stress, genetic/family diseases, etc. Members select and highlight the important areas, and may take turns reading the passages, and then discussing them. Some examples of a planned discussion topic include themes such as developing new substance-free social networks; interactions between mental health symptoms and substance abuse relapse; dealing with the stigma of a mental illness and a substance disorder, and so on. In contrast, planning an open discussion meeting does not include a topic; these meetings are open to discussing each individual's issues or concerns without a particular common focus. Meetings that include an invited outside speaker usually need to be planned more than one week ahead and involve scheduling a speaker around a particular topic.

Benefits to Participants

This program demonstrates that MICAA consumers are enthusiastic about taking responsibility for their own self-help program and motivated to assist others. They are eager and competent to provide leadership, support and opportunity to their peers. In effect, they can provide a positive working model of support and education and make improvements in the system's gaps in services for the dually diagnosed. Benefits from participating in this program included personal development inherent in new roles and responsibilities, and an increase in support and stabilization. The benefits from each participant's exploration of his or her dual disorders varied in degree from gaining insight to attaining or maintaining abstinence. Each participant experienced some benefit, regardless of length of participation. Participants gained insight into their addictive disorders and the interactions of their dual disorders through their ability to be candid among their peers; through the support and insight they provided for one another; through the educational materials and topics they selected and explored; and through the peer identity formed among the members. In particular, peer identity is not found in programs that do not address all of the symptoms and experiences of the MICAA consumer. This is not to be underestimated. One of the healing factors of self help programs is peer identification with others who understand each others' symptoms and plights. In "Helpful People in Touch," all symptoms were accepted and explored in a non-judgemental, non-threatening manner, and were understood by everyone. Consumers were not ostracized or stigmatized and therefore could openly identify with their mutual experiences. These opportunities allowed consumers to assist one another in their movement along the continuum to sobriety, stable mental health, and community living.

The initial planning meetings constituted hard work and a lot of thought and decision making. Some members expected to talk about their own situation instead. Others found planning difficult or stressful, but each member met the challange. The majority of the members agreed that it was the planning and decision making that made "Helpful People in Touch" truly their own program. At the end of the planning phase, members exuded personal satisfaction and a sense of ownership of their program.

The presence of a professional in the planning phase appears to benefit this process by freeing up participants to focus exclusively on the decision making process. It also provides a model of leadership and group process that may be adopted or changed by participants. An outside leader at the onset may also foster equality in the "shared" consumer leadership that follows. If a participant were to organize and lead the planning phase, it would be important that he or she not be perceived as the leader of the program, since that may deem the group leaders that follow as subserviant to a primary leader. In this process, the exit of the professional leader removes what may be perceived as a level of leadership. It does not appear to be essential to the development of these programs that a professional leader be included. It does take the initiative of individuals to begin the organization of this process, and to acquire the space, equipment and materials that may be needed.

Some members were enthusiastic about the leadership role and volunteered to co-facilitate meetings early in the process. Group leading and other job responsibilities involved members in new ways. The importance of these responsibilities was unanimously heralded as essential to the program's stability by the members. In effect, the empowerment of developing, running, and sustaining their own program was met by responsibility, personal resources, and caring.

Considerations for Implementing Consumer-Led Self-Help Programs for MICAA

It is recommended that each consumer be referred by a provider. Since the program took place in a non-treatment setting, it was important to have a contact person in the event of an emergency or a crisis. The consumer is not required to be in a treatment program. For example, case management referrals were acceptable.

Strategic announcements for the program and upcoming meetings are important. Announcements sent to the Alliance for the Mentally Ill (AMI) local chapters facilitated consistent notices of upcoming meetings to a broad community of mental health advocates. Listings in self-help clearinghouse newsletters, local newspapers, and mailings to providers and institutions were important and ongoing.

This program was developed in a community where formal MICAA treatment programs had been implemented, and some members were recruited from these programs. This helped facilitate the development of this program in several ways. Those members who had received some formal MICAA treatment had begun to address some of their dual diagnosis issues and had some familiarity with them. The members who had previous MICAA treatment had experienced a non-confrontational, educational model of intervention, this led to the decision to include education in the self help program. Previous knowledge held by some of the members was useful in assisting others who had not addressed their dual disorders. It also facilitated acceptance of other members regardless of where they were along the continuum of readiness or motivation. For example, this group also attracted participants who had a history of adversity to formal treatment, and therefore had not previously attended any kind of programs at all. Such referrals often come from case managers or hospital discharge planners. However, from the beginning, leadership was rotated among members who had prior knowledge of MICAA issues and members who did not.

For participants with some prior MICAA treatment, the format provides new and advanced ways to address dual diagnosis issues, and opportunities for new roles in group participation. Consumers who receive formal treatment elsewhere continue to do so. This program is intended to provide additional support and networking as part of each individual's over-all plan of recovery. The program is an example of a consumer-led adjunct to treatment or to traditional self-help programs, depending upon the situation of the individual. For some members, it is their only involvement in programming. "Helpful People in Touch" provides a positive working program model for support, peer identity, growth and change, for people who have not had this opportunity, and who prefer this program to others available.

Consumer Experiences and Comments

In February 1991, more than two years into this program, four of the core members spoke about their experiences in this program. The members were told that their interviews may become part of a verbal presentation and/or a written article with the use of pseudonyms. Each member gave written consent and the group session was audio taped (Sciacca, 1992). Their comments addressed diverse areas of this process. Some excerpts include:

Don: "I think being a facilitator or co-facilitator or even being called on as a member of the group can help more inhibited types perhaps even function at a higher level. I found the group helped me along because I had a lot of trouble with public speaking, but at one point I was leading the group with maybe eight or nine members. I found it was helpful the way it was structured and it got me over some of my shyness. I didn't feel at ease to talk to large groups. I led it for two or three months I think, and I found that the subjects we'd talk about and the films we saw—it was a good group to go to. I wish that it was run more often and with more people and more films. "

Joe: "I came in when the planning was going on, I felt there were too many rules, too much business. I know most people liked that. After a while, I dropped out because it wasn't fun. I came back for something to do. I liked meeting new people. I find it difficult to lead the group when the people don't know me. I really like staff-run groups; I don't know why I'm that way. I like shopping; I did shopping for at least two or three months. As long as this group is here, I'll still come."

Bob: "When I was facilitator and went to buy cookies it gave me something to look forward to. These people are depending on me for cookies, leading. If I'm not here the group ain't going to go. I got something out of the group. I've seen what I'm doing to myself in the long run, but I'm still doing it. I was brought here for a D.W.I. (driving while intoxicated) referred by a case manager; I came here by myself. I also have a mental problem where I'm taking medication. I'm still drinking; I haven't changed my way. I didn't know I was an alcoholic; now I know I'm an alcoholic. I was very relaxed with the group, even though I was drinking. I was comfortable because they understood my problem. I like leading—not for self-esteem or anything like that. I wanted to try to conduct...if I could help somebody out, I would help somebody out."

Mark: "There were a lot of people when I first came in. Then I left and went into the hospital. I realized that when you're on medication and you drink, it's a lot more serious. I take a drink, it exaggerates everything, alcohol exaggerates everything. Before this group I didn't have any treatment. I got medication from the pharmacy. This is the only place I come to; it's fun. Before I came here I didn't realize it was that much of a problem. Because I have this group, I have something to think about during the week."

Some of the previous members of this "Helpful People in Touch" group have moved on to more traditional self-help programs. Others have moved out of the community, or dropped out of the group for other reasons. This particular group sustained itself for more than three years. A core group of seven members was the stable force, with other members remaining for various lengths of time. New participants were accepted as space allowed.

Challenges Met by This Group

Some of the deterrents to the growth and stability of this program were discussed by the members in 1991. These included change of program space and loss of mailing funds. When the Training Site was closed (due to budgetary cuts), the group was relocated to a clinical setting. Members stated that the

clinical setting did not provide the privacy or exclusive use of the kitchen for preparing refreshments, and it was not as pleasing visually as the previous meeting place. This change interfered with job responsibilities (refreshments) which as a result were frequently taken on by the professional monitor to avoid conflicts. Members unanimously expressed their agreement that the structure for job responsibilities should not deteriorate. They experienced these responsibilities as a factor that further involved them in the process.

The notices of each meeting which were mailed to numerous professionals, family groups, consumers and members, were discontinued due to loss of funds for postage costs. This was replaced by a limited telephone chain that only included members in attendance, and therefore did not usually generate new members.

The members were clear about the areas they believed required rejuvenation and support. They considered changing the location to a church room or other non-treatment oriented milieu. New ideas included doing personal outreach at existing MICAA treatment programs by visiting and discussing the program. This regrouping (1991a) gave members the opportunity to address the changes that took place. The commitment expressed by the core members to continue their group was clearly evident. The meeting gave them an opportunity to explore the reasons why they were invested in the survival of this program, and to consider solutions to the changes that disrupted the original structure.

Other challenges for members included overcoming internal conflicts among themselves, including personality conflicts. The challenges of new roles and responsibilities did not appear to be as stressful. They were met with enthusiasm for the most part, even though some members needed to overcome personal obstacles. Flexibility is important in sustaining the program. Changes in meeting times such as day of week, time of day, and frequency of meetings may need to be revised to accommodate members or to sustain the continuation of the group. Each of these challenges was met by the members of this group.

Subsequent Groups and Materials

This program has been implemented in other communities and as a part of other program models where MICAA treatment programs have preceded them. In one subsequent program implemented in the clubhouse model of service, additional materials were developed at the request of the members. This included a structured interview to be conducted by two members with each new applicant prior to attendance. These members requested group leadership training that was provided after the planning sessions were completed. This group had the goal of presenting their program to community groups and other programs for purposes of recruitment and education. Guidelines for their presentation were developed along with a video tape of excerpts of the planning sessions and the group leadership training.

Resources Needed for Program Development

The supports necessary to develop a new group include temporary leadership, clerical services, meeting space, and availability of equipment and educational materials. The sustenance of a group requires some motivation and commitment from the original members and continued outreach for new members and group building. Long term sustenance requires motivation of the members, continued outreach, and stable supports. Ideally, if there is an initial provider leader, turned monitor, he or she could remain available to support the efforts necessary for long term sustenance. The meetings, on the other hand, are sustained by the leadership and participation of the members. The resources such as space, funds, and in this group, eventually the monitor, were not in the control of the members. A cohesive group may be able to replace these resources if called upon to do so, but would still need to rely upon the affluence of the community.

In sum, in each of the programs developed thus far, "Helpful People in Touch" has provided a positive example of a consumer-led self-help program for people with dual disorders of severe mental illness, drug addiction and/or alcoholism. Consumers demonstrate both a willingness to take responsibility for developing these groups and the ability to maintain them. They also demonstrate an enthusiasm in their efforts to help others who have dual disorders, and to have their own needs met. As a result, the symptoms of their dual disorders may be greatly improved and stabilized. For some, this program may be the only place to reap these benefits, particularly in communities that lack services and program models for persons with dual diagnosis, and/or rely upon traditional self-help programs.

Consumers and providers are clearly in a position to foster the development of new and similar groups, and thereby provide opportunities for growth and support to many people who may benefit.

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