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ORIGINAL ARTICLE

Mental Health Consumer-Operated Services Organizations in the US: Citizenship as a Core Function and Strategy for Growth

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Abstract Consumer-operated services organizations (COSOs) are independent, non-profit organizations that provide peer support and other non-clinical services to seriously mentally ill people. Mental health consumers provide many of these services and make up at least a majority of the organization's leadership. Although the dominant conception of the COSO is as an adjunct to clinical care in the public mental health system, this paper reconceives the organization as a civic association and thereby a locus of citizenship. Drawing on empirical research on COSOs in one state and the citizenship and civic democracy literatures, COSOs are analyzed here as membership organizations with democratic norms and strong ties to local communities. The suggestion is made that by embracing and enhancing their status as civic associations, COSOs may advance the goals of the social movement that spawned them and avoid predictable obstacles to further growth and development.

Keywords Citizenship · Civic associations · Civic democracy · Consumer-operated services · Mental health · Self-help organizations · US

Introduction

The plight of seriously mentally ill people in the US is well documented. Since the large-scale deinstitutionalization of state mental hospital patients in the middle of the last century, people with psychiatric disabilities have experienced disproportionate rates of homelessness [31], incarceration [20] and premature death [17]. The quality of public mental health services is questionable and varies widely by state

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[22]. Psychiatrically disabled people are, moreover, caught in public policy's "poverty trap" [30] where employment may lead to a loss of mental health benefits. Despite a long-standing policy commitment to community-based mental health care, mentally ill people are "in the community but not of it" [36].

Policy-makers have taken two distinct approaches to improving the conditions under which seriously mentally ill people live. One approach seeks to "reinstitutionalize" people with psychiatric disabilities—if not in actual mental hospitals then through a variety of coercive measures in the community, e.g., outpatient commitment [34]. The other approach, based loosely on the principles of the recovery movement [32], emphasizes self-determination, with or without clinical care, but always with peer support and an eye toward community integration. Because the mental health literature is informed largely by psychology or social work, citizenship as an element of community life is rarely referenced. Sayce [27], however, addresses the transition "from psychiatric patient to citizen" (subtitle), and Ware et al. [36] conceptualize citizenship as definitive of social integration.

Consumer-operated services organizations (COSOs) embody the second approach above. They are, as defined in this paper, independent, non-profit organizations, funded largely by state and local mental health authorities to provide peer support and other non-clinical services to consumers in the public mental health system. COSOs are governed by a board the majority of whose members must be mental health consumers themselves, i.e., consumers of mental health services, and although some COSOs allow non-consumer directors, it is majority-consumer boards that hire and fire them. In previous studies, COSOs have been treated as service providers with a unique peer-to-peer orientation. The purpose of this paper is to expand that view by exploring COSOs as civic associations in which and through which the citizenship of mentally ill people is expressed. By appreciating the COSO as a locus of citizenship, it is possible to: deepen our understanding of COSOs and their role in community mental health care; propose strategies for COSOs' growth and development; and elaborate on scholarship regarding new forms of US civic association.

Citizenship and Mental Illness

Discourse about the meaning of citizenship is central to Western political thought. Citizens may participate in a collective struggle for the good society, a sanctioned pursuit of self-interest, or a contract to leave the "state of nature." Citizenship is a shared status, and whatever its prerogatives, it denotes membership and agency. Citizenship rights may be civil, political or social, and although theorists disagree about whether the definition of citizenship is universal or particularistic, a belief in the desirability of active, participatory citizenship is widely shared [3]. One recent discussion of active citizenship connects it to concepts foundational to the recovery movement: community, inclusion, and empowerment [6]. According to these authors, empowerment joins the personal and political, and this route to citizenship may appeal particularly to those whose personal characteristics have been grounds for exclusion in the past.

Despite the resonance of citizenship themes with recovery movement goals, disability, especially psychiatric disability, has been problematic for citizenship theory. To be sure, the disability rights movement has, since the 1970s, insisted on equal rights for disabled people, not least because it found society to be a primary contributor to their disablement [9]. Equality for disabled people, however, requires the unequal—or at least non-uniform—distribution of benefits and the "reasonable accommodation" (in the words of the American with Disabilities Act) of needs. Furthermore, as Nussbaum [23] points out, theories of justice issuing from contract theory posit equally capable citizens seeking mutual advantage, and disabled people may not be, or be perceived as, equally capable. Nussbaum [23] offers a noncontractarian alternative, where citizens act to achieve shared ends, including fundamental entitlements in the name of justice. Beckett [3] too recognizes varying levels of individual need, but he universalizes human vulnerability, broadly construed, as the basis for citizenship. Here citizenship is a process wherein individuals claim a right to protection from the effects of potential vulnerability. (Beckett's view reminds one of disability activists' reference to non-disabled people as TABs or temporarily able-bodied). In the case of serious mental illness, however, non-disabled citizens may be less willing to see themselves as potentially vulnerable.

Serious mental illness is perhaps the disability least compatible with common and scholarly understandings of citizenship. Psychiatric disability may affect cognition and communication, and it complicates the attribution of free will. It raises questions not only of competence but self-control. Still, in the wake of deinstitutionalization, mentally ill people have taken their citizenship seriously. Despite the fact that they are for the most part economically disadvantaged and highly stigmatized, seriously mentally ill people have organized politically to affect a range of mental health policy issues, including support for consumer initiatives, including COSOs. They have also achieved self-governance in local, state and national consumer organizations [7].

COSOs originated in the ex-patient/survivor movement of the 1970s. Movement leaders, who were typically deinstitutionalized state hospital patients, mobilized other consumers on issues of civil rights and community supports, including consumer-run alternatives or adjuncts to psychiatric care. Two networks, the National Mental Health Consumers Association and the National Association of Mental Patients (later Psychiatric Survivors) spearheaded organizing at the national level, and in 1977, the National Institute of Mental Health (NIMH) created the Community Support Program (CSP), which assisted consumer groups of various kinds. Federal legislation then mandated consumer participation in advisory bodies to all mental health programs, further legitimating consumers' contribution to their own well-being. Demand for COSOs grew, and in 1993, CSP founded the National Empowerment Center (NEC) whose charge was to provide technical assistance to COSOs and other consumer groups [26]. The NEC still operates as do other similar centers, and the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has recently determined consumer-operated services to be an "evidence-based practice" worthy of a "toolkit" that will advance its adoption [13].

COSOs originated in an era when US civil society appears to have been in decline. Scholars working from divergent political perspectives have found cause for concern about the future of associations that are neither governmental nor market-based [1, 25, 28]. These civic associations serve important purposes, including the inculcation of democratic values, the provision of mutual aid, and the opportunity for community service. As the building blocks of civil society, civic associations democratize government and civilize the market [1]. Putnam [25] and other theorists of social capital find that civic associations create local ties, provide information, and establish norms, i.e., they create society's "glue." Skocpol [28] replies to Putnam, finding that civic associations, in particular federated membership organizations, have played an important role nationally as well as locally and politically as well as socially. For these scholars and others like them [6], the nature of our civic associations determines the nature of our democracy. This is true not only because democratic government depends on a robust civil sphere, but because civic associations provide an experience of self-governance and community engagement; they are in Skocpol's words, "pathways to democratic citizenship" (2003: 98).

For the most part, the civil society literature views associations among marginalized populations, such as mentally ill people, as something other than civic associations. Although Skocpol [28] notes that "certain kinds of local and intimate groups seem to have flourished in recent decades" (152), she does not view these mutual support or self-help groups as comparable to, say, federated membership organizations. Wasserman [37] also points out that self-help groups organized around a stigmatized condition or traumatic event have proliferated as traditional civic associations, such as the PTA, have declined. He compares the former unfavorably to the latter on several grounds: self-help groups focus on deviance rather than commonality; they are inward- rather than outward-looking; and they may actually "supplant rather than strengthen local community" (241–242). In this view, self-help organizations may serve legitimate purposes, but they are not constitutive of civic democracy.

It is the contention of this paper that COSOs will surprise students of civil society (and perhaps of mental health). Although they originate in an impulse toward self-help among stigmatized individuals, COSOs are actually more like other membership organizations than might be expected. Inquiry through the lens of civic democracy finds the citizenship skill-building and leadership opportunities, the multiplicity of organizational pursuits, and the engagement in larger community issues that Skocpol [28] identifies in the federated membership organizations of the past. Moreover, from the point of view of COSOs and their advocates enhancing the civic aspects of organizational life may prove a successful strategy for growth and development, even under conditions of budgetary retrenchment.

COSO Profiles in One State

Mental health consumer organizations take various forms and are categorized differently in different published typologies [16, 21]. The definition of a COSO

above—an independent, non-profit organization (designated in the US tax code as a 501(c)3 organization) with a majority-consumer board and peer-to-peer orientation—is neither unique nor universal and comports with regulatory requirements in the state where this research was conducted. The COSO as defined is also a membership organization; participants are referred to as members and determine, through formal and informal processes, what the organization does and how.

The empirical component of this paper is a 2-year study funded by a state mental health authority (SMHA) to assess the role of COSOs in the public mental health system in that state. Data were collected by mail survey ($n = 17$) and telephone interview ($n = 6$) from the directors of a geographically representative sample of COSOs. The data were analyzed to construct organizational and environmental profiles of these organizations, i.e., to depict their internal structures and processes and their external relationships with the larger mental health system and the local community. Given the small sample size and use of descriptive statistics, the results of this study must be viewed as exploratory. It is, however, the first to consider COSOs' relationships beyond the mental health system and their full potential as loci of citizenship.

The organizational profiles of COSOs reveal significant variation but also strong similarities. Their mean number of years in existence is almost 16; COSOs in this state are both well established and newly organized, with a range on the age variable of 4–47 years. The mean number of members is 237, with a median of 200 and a range of 30–600. On average, COSOs operate at least 5 days per week and 8 h per day. Eighty percent provide all of the following services: peer support, social activities, information and referral, classes taught by consumers, crafts, self- and system advocacy, and wellness activities. Large majorities also provide meals and help with public benefits. A small percentage of COSOs provide computer classes, classes to prepare for the secondary school equivalency exam, housing and respite. Many services are initiated and provided—with or without pay—by members themselves. Every COSO actively solicits feedback, and more than half of COSOs collect dues from their members. In addition, 40% collect cash and 53.3% collect in-kind member contributions.

By definition, all COSOs have governing boards and by-laws. The average number of board members is about 10, and the requirement for consumer representation ranges from 51 to 100% of board membership. Every COSO in this state elects its governing board, and over 90% have standing board committees. In interviews, COSO directors described their boards' responsibilities as overall governance, including approval and oversight of the budget, evaluation of the director, and a range of planning and policy-making activities. For example, in one COSO, the board became aware that some consumer-employees risked losing public income maintenance benefits on account of their COSO earnings; the board's response was to pay these employees with gift cards that would not be deemed in calculating their incomes. In another COSO, the board represents the final step in the member and staff grievance processes, and in another, it is charged with making required budget cuts "fairly." A number of directors noted board members' commitment to the mission of the COSO and their grasp of and belief in its potential.

The COSOs studied have median annual budgets of $200,000, with a range of $44,000 to $1.3 million. Eighty-five percent have formal fiscal policies. About two-thirds of COSOs receive grants and enter into contracts, and funders beyond the mental health system include United Way (a large charitable organization), the Bureau of Vocational Rehabilitation, and foundation grants. Most COSOs also build revenues through fund-raising activities.

Consumers come to COSOs after hearing about them from other consumers (93.3% of COSOs), the local mental health board (LMHB) (80%), community mental health centers or providers (86.7) or hospital personnel (53.3%). Eighty percent of COSOs have formal disciplinary/exclusion policies that are implemented by members, boards and staff. According to interview data, these policies vary in some particulars (such as the role of the staff), but every COSO makes the rules of the organization explicit and these emphasize the well-being of individual members.

The environmental profiles of COSOs attest to ongoing relationships between these organizations and other actors inside and outside the mental health system. When asked to rate the relationship of the COSO to the SMHA, directors most often chose the middle value, "good" (33%), although more than half said either "very good" or "excellent." Almost 90% of COSOs receive moral support from the SMHA, and 75% are provided with networking opportunities. COSOs rate their relationships with LMHBs even more favorably, with over three-quarters responding that they are "very good" or "excellent." Every COSO receives financial support from the LMHB, and this funding accounts for a median 90% of COSO budgets. Eighty percent receive moral support and 73.3% networking opportunities from the LMHB. More than 70% of COSOs report "strong" or "very strong" communication with the LMHB, and more than two-thirds provide the LMHB with educational materials and consumer expertise.

Every COSO reported a relationship with mental health providers, including community mental health centers. In interviews, directors frequently described relationships with providers as difficult: these may ignore the presence of COSOs in their communities or even advise patients against joining them. Respondents attributed this behavior to providers' disinterest or lack of understanding as well as their belief that peer-provided services cannot be beneficial to mentally ill people. In one case, the COSO enjoys a good relationship with individual clinicians at the local mental health center but not so with the administrator, who has allegedly stated that COSOs are unproductive and that she would like to run the organizations herself. COSOs, in turn, implement a variety of strategies to manage their relationships with providers: to keep communicating, to be helpful to providers through referrals, to avoid criticism of providers, to be persuasive about the value of COSOs, and to ask for providers' advice even when it is not necessary. COSOs seek to diminish any perceived threat to providers by "staying off their turf," emphasizing that each type of organization has its own role, and describing the role of COSOs as a "wrap-around" for clinical care. Despite this intentional differentiation, survey data reveal that almost two-thirds of COSOs provide services previously provided by mental health agencies, and 46.7% know of agencies that provide services previously provided by them.

Beyond the mental health system, COSOs form relationships of different kinds with other community organizations. COSOs receive assistance from them in the form of in-kind contributions (64.3% of COSOs), information and education (64.3%), technical assistance (50%), financial assistance (28.6%) and moral support (71.4%). COSOs, furthermore, give as well as receive. They provide assistance to other community groups in the form of in-kind contributions (57.1% of COSOs), information and education (64.3%), technical assistance (42.9%) and moral support (64.3%). A majority of COSOs undertake joint projects with non-mental health community organizations. Almost 93% refer members to other groups, and 85.7% of COSOs receive referrals from them. COSOs (85.7%) advocate for other organizations, and these groups advocate for 71.4% of COSOs.

In interviews, COSO directors identified the non-mental health organizations with whom their organizations have formed relationships. These may be summarized as follows: churches, church groups and ministries; food banks and pantries; clothing banks; free clinics; shelters and housing authorities and coalitions; private social service agencies; service clubs, e.g., the Kiwanis Club, a global service organization that undertakes community projects; law enforcement; public schools; colleges and universities; Salvation Army and Volunteers of America; United Way; Humane Society; the county fair; nursing homes; and local public or quasi-public agencies such as the human services agency, the area agency on aging, the developmental disabilities board, and the community action (poverty) agency. Some COSOs have more of these relationships and some fewer, but every COSO director offered some kind of list. Among the specific projects undertaken by COSOs and their community partners were: the distribution of a children's book about bipolar disorder (with the Kiwanis Club); providing COSO respite beds to accommodate homeless shelter overflow; a task force to the address the local panhandling problem; a benefits bank; therapy dog visits to nursing homes residents; internships and service learning opportunities; providing a site for criminal community service sentences; training local law enforcement in mental health crisis intervention; myriad "walks" for various causes; and campaigns for tax levies to fund mental health and other human services.

Internal to the COSO, peer support is the service on which all other services are built. It is a fundamental principle of the recovery movement and is thought to be essential to recovery from mental illness. Peer support has been found to be clinically effective [29], but its initial logic was the belief that despite their societal devaluation, psychiatric patients had something to offer one another. Mutual support, of course, is a feature of groups formed to respond to a variety conditions and events. In the case of mental illness, however, participation in peer support flouted both professional and public assessments of the capabilities of the people involved. It democratized the giving and receiving of help [26] for people who knew well the rigid hierarchy of the mental hospital. As in other kinds of mutual support, peer support among mentally ill people privileges experiential knowledge [5]; it is based on the belief that there are fundamental understandings of mental illness inaccessible to those who do not experience it. Because seriously mentally ill people are also for the most part economically and politically disempowered, peer support may also impart experiential knowledge of scraping by and working the system.

Peer support has as its goal the empowerment of psychiatrically disabled people, as individuals and as a group. Empowerment, like peer-support a principle of the recovery movement, is more than an ideological construct. Now the province of psychometricians, empowerment has been shown to result in better mental health outcomes [10]. COSOs are designed to be empowering; participation is voluntary, members are self-governing, and self- or system advocacy training is one of the services offered. Empowerment connects peer support to agency—in the COSO and beyond. One study found, for example, that nearly 20% of members of self-help groups had written letters to their elected officials during the previous year and that 55% had voted in the last election (a higher percentage than voting-age Americans overall [8, 15]. Nearly all the COSO directors interviewed described the founding of their organizations as an act of consumer agency. Simple peer-support groups, often under the auspices of another agency, were found lacking by their participants, who then transformed them into multi-service organizations whose members were in control. At least as this history is told, support groups made the decision to do more and to do it independently.

Externally, in relationships in the mental health system, COSOs straddle two identities: as service agencies on the one hand and as peer organizations on the other, i.e., as providers and consumers, even as friends and foes. COSOs, as noted, were born of deep dissatisfaction and mistrust; they now provide services in a public system against which they were once arrayed. This is, perhaps, an instance of cooptation, i.e., public funds may have been deployed to quell consumer discontent. Just as plausibly, it is a marriage of convenience: COSOs must have public funds, and state and local mental health authorities must have community service providers. Dire financial and workforce conditions in the public mental health system have created tolerant if not intimate bedfellows. More to the point, however, the establishment of COSOs as independent, non-profit organizations serves both identities and opens the door to citizenship. Because 501(c)3 organizations are self-governing, they channel the mental health consumer movement through democratic structures such as board elections and levy campaigns. By the same token, because COSOs are 501(c)3's like other provider agencies, the former are viewed similarly by the LMHB and are invited to participate in decision-making affecting the local mental health system as a whole.

In relationships beyond the mental health system, COSOs partners in service provision, especially to poor people, in civic engagement, and in political activity. It is impossible to know from the data collected what percentage of COSO members are involved in these community-wide enterprises. Perhaps participation is concentrated among staff, board members or a small group of members; for example, the decision to allow homeless shelter clients to occupy COSO respite beds was likely made at the director level. Still, it is worth noting that COSOs offer broad and varied opportunities for community involvement, and whereas some are for consumers qua consumers, e.g., training law enforcement in mental health crisis intervention, others have nothing to do with consumers' experience of mental illness, e.g., bringing therapy dogs to nursing homes. Furthermore, COSOs not only provide members with entry into community life. They draw members of other community groups into the organizational life of COSOs. Given that contact is the

most potent antidote to stigma [27], these relationships may remove obstacles to community integration regardless of the content of a given project.

The COSO as a Locus of Citizenship

The name "consumer-operated services organization" is hardly suggestive of democratic citizenship. The "consumer" in COSO is a consumer of mental health services, and this terminology replaced the more passive term "patient" to connote a more active participant in the "market" for psychiatric treatment. As consumers, mentally ill people would presumably have a say in how they were treated, and the replacement of the medical model with the market model was putatively a more positive identity for people with psychiatric disabilities. The fact that consumers, at least in the public mental health system, had little choice about their services did not inhibit adoption of the term. The naming of mentally ill people "consumers" or, in the British version, "users," has been challenged on several grounds. Cowden and Singh [12] point up the impotence of most consumers and argue that without addressing the issue of power, "the voice of the User becomes a fetish," i.e., something that purports to represent "authenticity and truth" but exerts no real influence (15). Bolzan and Gale [4] argue that in fact, mentally ill people exercise agency not as consumers but as members of networks—as peers who define their needs and devise ways to meet them. The authors refer to this as "social citizenship." Alford (2002) agrees and finds the focus on consumerism devaluing of the citizenship of mentally ill people.

The "services" in COSO consist of those listed above and any others that an organization chooses to provide. They are never clinical services (although they may include case management), and the COSOs studied here hold themselves out as adjunct to professional services, another station on the continuum of mental health care. In interviews, however, some COSO directors described this presentation as strategic rather than substantive—a way of eliciting good will from professionals and professional agencies. Moreover, the option to further professionalize COSOs in order to earn Medicaid (public medical insurance) certification was the subject of intense debate among COSO directors and members and the statewide consumer organization during the period of this study. The emphasis on service provision has surely legitimized COSOs in the public mental health system and the larger human services universe. It has been instrumental in securing funding from mental health authorities and in attracting new members. It does, however, like the term consumer, obscure the other functions of COSOs. Peer support, for example, may be deemed a service—and in fact, "peer support specialist" is in some quarters a vocational category—but it is also a variety of self-help [26]. Similarly, participants in "system advocacy" are as much political actors as dissatisfied consumers. Even from a strategic perspective, the emphasis on service provision may create as many problems as it solves, especially in relationships with providers. Barnes [2] notes the existence of "professional defensiveness," and the COSOs studied experience disparagement by and resistance from clinical professionals and administrators of clinical services. COSO directors may believe that calling themselves adjunct

service providers minimizes the threat perceived by professionals around them, but both COSOs and providers are funded by the LMHB, and they remain competitors for scarce mental health resources. Because consumer-operated services are less costly to public payers, it is in the interest of provider agencies to establish their own superiority by raising doubts about the competence and reliability of COSOs.

COSOs might resolve to recognize and publicize their status as civic associations. Although they do not replicate the cross-class, federated membership organizations celebrated by Skocpol [28], they are membership organizations nevertheless. Members are generally poor, but not always, and low-income members may have been solidly middle-class until serious mental illness compromised their employability and family ties. COSOs are not federated, but in the state studied, they are linked to a statewide association of COSOs and to national organizations committed to supporting them. COSOs undertake multiple organizational pursuits; like Skocpol's [28] civic associations of the 1950s, they offer social activities, opportunities for community service, mutual aid, and attention to public affairs, especially as these affect people with mental illness and other poor people. As Skocpol [28] herself explains, even the supposedly impermanent interpersonal groups depicted by Wuthnow [38] are "(like classic local groups but in new ways) institutionally embedded, dependent on resources, networks, and organizationally embodied meanings larger than themselves" (168). How much more so for COSOs, which combine peer support, self-governance, and community involvement—the personal and the political?

In response to Wasserman [37], COSOs demonstrate that although their members are deviant (by society's measure) and look inward to make sense of what has happened to them, they are motivated by a desire for what normality brings—economic self-sufficiency, family life, and an absence of stigma—and they look outward toward the larger mental health system and their communities. (It is an old saw of the recovery movement that consumers want what everybody else wants: a good job, a safe place to live, and a date on Saturday night.) This is not only because consumers "realized that quality of life was rooted in fully experiencing the opportunities and problems of one's neighborhood" [10]. Rather, the life circumstances of COSO members draw these organizations into relationships with other community groups, local agencies and churches, especially those groups engaged in anti-poverty and public safety efforts. COSOs represent the ideals of a social movement, but their day-to-day work is with members, who have practical problems and local aspirations.

What would it mean for COSOs to recognize and publicize their status as civic associations? One COSO director described his organization as being "like the Kiwanis club," and another focused the interviewer not only on what his COSO did (provide services) but how it did it (through processes of self-governance). Still, given their reliance on mental health system monies and their susceptibility to hegemonic market models, COSOs have little incentive to explore their role in civic democracy. Developments in the public mental health system also militate against an understanding of COSOs as loci of citizenship. Evidence-based practice (EBP) in mental health has been endorsed by researchers, policy-makers and some patient groups as the primary strategy by which to improve mental health services [33].

Like evidence-based medicine (EBM) before it, EBP is an applied-science model of knowledge and practice, whereby poor-quality mental health care results from insufficient implementation of scientific findings about "what works." Higher quality, in this view, will result from policies that ensure the "fidelity" of everyday practice to research-based protocols. Applied science does not consider citizenship. It strives for uniformity in implementing what works, diminishing opportunities for organizational and individual self-determination and the local variability these create.

A second development in the public mental health system is the necessity, especially when there are budget shortfalls, to attend first to the responsibility for social control. In the state studied, a full 50% of public mental hospital beds are occupied by mentally ill offenders who have been place there by the courts [19]. More to the point are threats to public order, real or perceived, posed by mentally ill people who have not been adjudicated as criminals [35]. Although mentally ill people are far more likely to be victims than perpetrators of crime [18], the public perception is otherwise [24], and state and local mental health authorities are charged with minimizing conflict between mentally ill people and their neighbors. In this context, the mental health authorities may be less concerned about empowering clients than restraining them. Anecdotally, one SMHA staffer responded to discussion of this research by throwing up her hands: "We get the call when a client pees on his neighbor's lawn. Isn't there enough empowerment?"

In order to be successful citizenship organizations, COSOs will have to respond to the ascendance of EBP and the focus on social control. In the first instance, mental health researchers could begin to define and measure citizenship and analyze it as a dependent and independent variable; this is already true of the equally awkward "empowerment" [11]. Although any such citizenship measures are likely to be reductionistic in the extreme, they will introduce and presumably legitimate citizenship as an element of mental health recovery. COSOs, in turn, will be no more confined to research definitions of citizenship than they are currently with regard to empowerment. The operationalization of citizenship for mental health research may have the additional benefit of focusing COSOs on particular opportunities for self-governance and community involvement. More attention might be paid to (and assistance sought with) the range of deliberative processes that inform organizational actions. COSOs might seek out community partners for citizenship-building, such as the League of Women Voters or other non-partisan voter groups, and although COSOs did report relationships with some service clubs, self-identifying as a civic association might spur outreach efforts by COSOs to other service clubs and to voluntary associations of other kinds.

The public mental health system may, in this time of ever scarcer resources, devote particular attention to social control; empowerment of mentally ill people may seem a luxury or even a menace. To continue the anecdote above, however, the SMHA staffer reconsidered her response when COSOs were defined as citizenship organizations—citizenship connoting responsibilities as well as rights, and norms, albeit democratic rather than psychiatric ones. The consumer/survivor movement in mental health originated in the extreme disenfranchisement of deinstitutionalized mental patients. It was in many ways a resistance movement, and consumer

empowerment was directed at interactions with the mental health system. Recasting COSOs as citizenship organizations does nothing to weaken their efforts toward social change, but it may, as in the encounter described, reassure authorities, professionals and neighbors that COSOs do not foment bad behavior; rather they support mental health recovery by engaging consumers in recognizable relationships within the organization and in the local community. In the case of professionals, this reassurance may extend to their distrust of peer-provided services. Identifying as civic associations, COSOs further distance themselves from clinical care, and they can claim an expertise that does not impinge on providers' own identities. COSOs and providers will continue to compete for resources, but COSOs will convey even more emphatically that they do not do what agencies do (only better).

Because the public mental health system depends increasingly on Medicaid funding [14], Medicaid certification for COSOs is one strategy for increasing revenues. Becoming a Medicaid provider, however, would require a certain professionalization of COSO operations, for example, in the areas of member record-keeping and supervision by clinical staff. As noted above, COSO directors in the state studied disagree about whether Medicaid funding is sufficient reason to depart from earlier models of peer-run organizations. If it proves to be, what will happen to the nascent civic association inside the COSO? Will having to look like a provider agency diminish these organizations' appetite and opportunities for civic democracy? One COSO director interviewed provided an utterly pragmatic answer. His organization (the largest in the state) is Medicaid-certified for case management services, but these are merely one offering by an organization that remains unambiguously self-governing and community-involved. The director (also a consumer) employs a non-consumer, clinical supervisor for case management, but the case managers themselves are also consumers, and the entire Medicaid enterprise is physically separate from the areas where members meet as members. The further "Medicaidization" of COSOs may subordinate membership to management [28], but this need not be the case.

Conclusion

This paper promised to achieve a deeper understanding of COSOs and to propose strategies for their growth and development. The COSO is indisputably a locus of self-help and mutual aid. The mental health system further defines these activities as "services" and COSOs as service providers. The COSO is also, it has been argued here, a locus of citizenship, a civic association with self-governing members and ties to the community. Psychiatric disability is a political, as well as personal, circumstance. It is not surprising that COSOs embody membership as well as management.

Skocpol has drawn a "conceptual map" (2003: 172–173) of membership and constituency associations in US civic life. The two axes are: (1) "governance and resource base" divided into "professionally run…" and "elected leaders…" and (2) "group speaks for" divided into elites, elites serving the community, public or cross-class constituency, and less advantaged. COSOs fit most comfortably in the

cell defined by elected leaders and the less advantaged; in Skocpol's rendering, it contains unions and populist farmers' associations. COSOs, perhaps surprisingly, represent a variation on this theme. Whereas unions and farmers' associations speak for less advantaged economic actors, COSOs do the same for seriously mentally ill people, who are less advantaged by virtue of their disability. The three groups share functions such as mutual aid and "system advocacy"; they are self-governing even with the addition of professional staff. COSOs are, of course, also different from Skocpol's groups. Their members are stigmatized and excluded, and dominant views of mental illness cast them as useless in a way that workers and farmers are not. The economic disadvantage that accrues to serious mental illness precludes COSOs from economic self-sufficiency. Their funding by the public mental health system, while entirely justified, undercuts their independence. Nevertheless, COSOs have remained loci of citizenship, even in a system that conceives of them as service providers (albeit with a peer-to-peer orientation). By conceiving of them as civic associations, we may discover hidden strengths—not just of consumer-operated service organizations but of civic democracy as well.

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