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MEMBER CHARACTERISTICS OF CONSUMER RUN ORGANIZATIONS AND SERVICE UTILIZATION PATTERNS*

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ABSTRACT

The present study examines the member characteristics of consumer-run organizations (CRO), nonprofit mutual help organizations staffed by mental health consumers. Members reported significantly higher levels of use of physical health services than psychological services. Twenty percent of members identified their CRO as their only means of psychological support. CRO members were more racially/ethnically diverse than mental health consumers in traditional settings indicating that CROs are attractive to minorities which are often underrepresented in receiving mental health services. CRO members' social networks were heavily composed of other CRO members, with church friends and family members also well represented. CRO membership may provide a social network effectively oriented toward recovery and community integration.

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Grounded in peer support, consumer run organizations (CROs) demonstrate the possibilities of mutual support groups by not only functioning as "drop-in" centers, but most typically working in the capacity of fully functioning nonprofit organizations staffed by mental health consumers (Brown, Shepherd, Merkle, Wituk, & Meissen, 2008; Brown, Shepherd, Wituk, & Meissen, 2007). Peer support services run by consumers outnumber traditional services for people with mental illness if peer run mental health self-help groups are included (Goldstrom, Campbell, Rogers, Lambert, Blacklow, Henderson, et al., 2006).

Highlighted by The President's New Freedom Commission on Mental Health (2002) as an emerging best practice (Silverman, Blank, & Taylor, 1997), CROs provide access to experiential knowledge that allows members to take a participatory role in the recovery process, which appears to be related to a variety of positive outcomes (Solomon, 2004). Despite their prevalence and positive outcomes, little is known about the characteristics of CRO members.

It is the purpose of this study to examine CRO member characteristics across four dimensions:

1. service utilization;
2. patterns of social interaction related to CRO relationships;
3. member involvement; and
4. demographics.

Service Utilization

CROs likely are the most frequently utilized mental health service for members of such organizations. Average members attend their CRO many times during a week (Holter & Mowbray, 2005; Segal & Silverman, 2002). CRO members utilize many different services that include both mental health services such as case management or therapy as well as non-mental health services provided by local physicians. Nelson et al. (2006b) found that within a 30-day period, 75% of CRO members utilized case management, and 71% visited a physician. Nelson et al. (2007) found that only 3.6% of active CRO members reported psychiatric hospitalization during a 36-month period.

Patterns of Social Interaction Related to CRO Relationships

For both consumers and non-consumers a long established relationship is noted between mental health and social support (Berkman, Glass, Brissette, & Seeman, 2000; Cohen, Gottlieb, & Underwood, 2000; Solomon, 2004). Research has shown that consumers have fewer social interactions than non-consumers while experiencing a greater number of negative, even traumatic social interactions (Eklund & Hansson, 2007). Thus, when both positive and negative social interactions take place, it is possible for the effects of negative social interactions to outmatch the possible benefits of positive social interactions (Newsom, Rook,

Nishishiba, Sorkin, & Mahan, 2005). However, in its most beneficial form, satisfying social support tends to facilitate health (Berkman et al., 2000; Newsom et al., 2005).

One possible concern regarding the social interaction of CRO members is the homogeneity of their social networks that is dominated by consumers. One study found that 48% of CRO members' social networks are composed of relationships with other members (Brown et al., 2008). It is argued that social integration requires having a fair number of people who are not mental health consumers within ones social network (Wong & Solomon, 2002). While homogeneous networks indeed foster support for shared values and ideas (McPherson, Smith-Lovin, & Cook, 2001), too much homogeneity in ones social network may not be most beneficial, especially if community integration is desirable. The lack of diversity makes change and the communication of outside ideas and resources more difficult (McPherson et al., 2001).

However, the social interactions that take place within the CRO appear to have a positive relationship with recovery (Brown et al., 2008; Mowbray, Robinson, & Halter, 2002; Nelson et al., 2006b; Solomon, 2004). The social interactions that take place at CROs nurture sense of community (Maton & Salem, 1995) and encourage community involvement (Mowbray & Tan, 1993), tending to reduce isolation, loneliness, and stigma (Gulcur, Tsemberis, Stefancic, & Greenwood, 2007). Hansson and Borkman (2007) found that over time social networks had a greater influence on perceived quality of life than did symptoms related to mental illness.

Member Involvement

Trainor et al. (1997) found that following participation in CROs, participants' reports of inpatient service usage decreased by 91%. Ochocka, Nelson, Janzen, and Trainor (2006) suggested that participation in CROs facilitates community integration. Involvement in mutual help organizations, such as CROs also has been found to be related to satisfaction with traditional mental health services (Hodges, Markward, Keele, & Evans, 2003), a finding consistent with self-help group participation. The length of involvement in CROs shows a positive relationship with mental health improvement; CRO members manifest fewer psychiatric symptoms subsequent to extensive CRO involvement (Ochocka et al., 2006). Members who are more active in their CROs gain greater benefit from being involved in the CRO than do those who are active less frequently (Brown et al., 2008).

CRO Member Demographics

Gender

The gender composition of CROs varies, with some researchers reporting a greater number of male than female CROs (Holter & Mowbray, 2005; Mowbray

et al., 2002), while research on peer support groups shows females making up a majority of the membership (Wituk, Shepherd, Slavich, Warren, & Meissen, 2000). Such variation likely reflects the characteristics of particular CROs (Holter & Mowbray, 2005; Mowbray et al., 2002).

Ethnicity

The racial composition of CROs appears related to the demographics of the region and the local mental health population and thus varies, people of color making up between 15% (Holter & Mowbray, 2005; Mowbray et al., 2002; Nelson et al., 2006b) to over 80% (Hardiman & Segal, 2003). Researchers in Michigan and Ontario, Canada found that between 80% and 85% of CRO members identified as Caucasian, with approximately 15% of CRO members identifying as African American. This is consistent with demographics for the area and corresponding public mental health population (Holter & Mowbray, 2005; Mowbray et al., 2002; Nelson et al., 2006b).

Research by Hardiman and Segal (2003) found 64% of members identifying as African American and only 17% as Caucasian in a low socioeconomic part of the Bay Area in California. Only a few studies have provided additional information regarding the racial composition of consumers of color who do not identify as African American. For example, Hardiman and Segal (2003) reported 7% of members identifying as Latino, and Brown et al. (2008) found that 3% of members identified as Hispanic, 2% identified as Native American, and 0.5% identified as Asian in Kansas. Mowbray, Robinson, and Holter (2002) noted fewer than 10% of members represented non-African-American consumers of color in Michigan.

Other Demographic Characteristics

Approximately half of CRO members have never been married (Brown et al., 2008; Nelson et al., 2006b), with as many as 21% having a spouse (Nelson et al., 2006b). The proportion of CRO members who are not currently married is considerably greater than found in the general population, while generally consistent with proportions in the public mental health system.

Around half of CRO members have some post-secondary education (Brown et al., 2008; Nelson et al., 2006b). Nelson et al. (2006b) found that approximately 66% of CRO members were employed or active in volunteering. As an emerging best practice, CROs are members' most frequently utilized mental health service.

Some research suggests that CRO usage has a positive influence on service utilization and reduces the manifestation of symptoms. It appears that some member characteristics such as ethnicity and gender are dependent upon the geographic location of the CRO.

METHODS

Participants

Eight CROs were recruited as part of a larger study based on a combination of the population density of the geographic area in which they were located, the number of members, and factors of organizational functioning such as the stability of the CRO. Choice of these eight CROs allowed selection of diverse participants from among the 20 Kansas CROs in operation in 2005. From the eight CROs (Table 1), 132 participants were recruited. For each CRO a sample proportionate to the membership based upon the CRO's average daily attendance, which provided a more accurate representation of those members who actively participate in the CRO than did total CRO membership. There were 66 males and 65 females, and one person for whom no data on gender was recorded. The sample consisted of 96 Caucasians, 19 African Americans, and the remainder of the sample consisted of a small number of participants belonging to various other ethnic or racial groups. Individuals who were in attendance at the CRO when the researchers were present were invited to participate in this study. Some CROs required multiple visits. The individuals participating in the study received five dollars as compensation for their time.

Measures

Service Utilization

A subset of questions from Access to Community Care and Effective Services and Supports (ACCESS) evaluation was used to measure the utilization of

Table 1. CRO Organizational Characteristics

CRO name	Location	Number of interviews	Average daily attendance	Number of members	Population[a]
Bridge to Freedom	Osawatomie	13	9	14	4,645
P.S. Club	Wellington	11	10	32	8,674
Open Door	Arkansas City	12	13	43	11,963
High Plains	Hays	7	7	33	20,013
Morning Star	Manhattan	15	14	86	44,733[b]
Sunshine Connection	Topeka	28	26	180	122,008[b]
S.I.D.E.	Kansas City	22	15	180	145,757[b]
Project Independence	Wichita	23	24	76	354,617[b]

[a]From 2000 United States Census unless otherwise noted.
[b]From 2003 United States Census population update.

services. ACCESS was a multi-site, longitudinal national project designed to integrate systems of treatment, supportive services, and housing for homeless persons with severe mental illness. Specific questions inquire regarding the number of days in the past 60 that various types of non-psychological medical, psychological, and substance related services were utilized. The services asked about include hospital treatment for both psychological and non-psychological reasons, use of case management services, use of dental services, and use of detox programs.

Patterns of Social Interaction Related to CRO Relationships

Social network size—Participants were asked to state the number of people with whom they felt close, for each of 10 categories: significant other, children, other family members, CRO related, employment related, professional health provider, religion related, recreational and hobby related and school related non-CRO friends. This measure was adapted from ACCESS for use with CROs.

Social participation—Participants were asked to indicate the frequency in which they participated in certain activities. The frequencies ranged from "daily" to "not at all in the past year," with activities including "visiting with friends" and visiting with relatives." This instrument is an adaptation of questions from the Techumseh Community Health Study. However, the authors, House, Robbins, and Metzner (1982), did not report the psychometric properties of this scale.

Member Involvement

Participants were asked about their length of membership in their CRO. Additionally, members were asked questions regarding their frequency of visiting the CRO. These questions measured average weekly frequency of attendance and average hours of attendance per visit.

CRO Member Demographics

Gender was determined by observation; however, in the case of androgyny, there were instructions to ask the participant's gender. Racial/ethnic identification data were collected using a list of nationally recognized racial groups, as well as providing an opportunity for the inclusion of racial or ethnic groups not mentioned in the list. Participants were asked to indicate all of the groups with which they identified. Marital status was identified by asking participants to select the marital status that currently applied. These questions were derived from the Consumer Operated Program Multisite Research Initiative (COSP), national, multi-site study examining consumer-operated services.

Members were asked to indicate their pattern of employment and volunteerism over the previous 60 days. This included questions about the regularity of work schedule and full- or part-time status, as well as inquiry as to whether the

member was a student or was disabled. The number of days worked for pay was also obtained as were the number of hours worked in the past 30 days and average hourly wage. These questions were derived from the ACCESS evaluation instruments.

Procedure

All members who attended the CRO at a pre-arranged time when the researchers were present were invited to participate in the study. Researchers circulated a sign-up sheet at the CRO, and the members who were interested in participating placed their name on the sheet. No members were refused an opportunity to participate. Members were in no way required to participate and could discontinue participation at any time.

Data collection took place at each of the participating CROs. The ability of the researchers to gather the preferred number of interviews determined the number of visits made to each CRO to collect data. Some CROs required multiple visits in order to collect enough member data to be representative of the organization's active membership. Most often, interviews were conducted one-on-one and administered in areas of the CROs that provided privacy. The researcher read the survey instrument aloud to the participant, and recorded his or her answers. Participants were provided a paper copy of the questionnaire as a reference.

In some instances, the interview was proctored to a small group of four or five members. This method, in conjunction with one-on-one administration, allowed researchers the ability to interview all available members on a given day. In the proctoring situation, a researcher was always available to answer questions. Following the completion of each survey, the researcher reviewed the completed survey for missing information and areas that required verification.

The administration of the instrument took on average 30 minutes. After completion of the interview, participants each received five dollars, and were asked to fill out a receipt as proof of payment.

RESULTS

Service Utilization

Psychological Services

Within 60 days of their interview, no hospitalization was reported for psychological issues by nearly 95% CRO members. During this same period, 86% of members did not use services of a day hospital or day treatment center. Additionally, 38% of CRO members had not seen a counselor or therapist within the prior 60 days. There was no use of case management services by 35% of CRO members during the previous 60 days.

Peer Support

Approximately 81% of CRO members reported having received no peer counseling within 60 days prior to their interview. There was no mental illness support group attendance for over 76% of CRO members. While the professional mental health services described in the previous paragraphs were available through community mental health centers, peer counseling and support groups were not available in all areas, especially those that were rural. Table 2 contains detailed information on psychological service utilization.

Drug and Alcohol Services

Detox treatment or "sobering programs" were used by less than 1% of CRO members during the 60 days before their interview and AA or NA was attended by 5% of members during this same time. Overall, very few members in this sample were actively receiving services related to addiction. Overall drug and alcohol service utilization data are detailed in Table 2.

Medical Services

Approximately 60% of CRO members use services for physical issues (non-psychiatric), substantially more than for mental health or substance use treatment during the 60 days prior to the interview. Over 28% of CRO members visited a doctor or nurse more two or more times in that same period. The detailed frequencies and means related to overall medical service utilization are presented in Table 2.

Patterns of Social Interaction Related to CRO Relationships

At least once per week, over 70% of CRO members visit with friends and 19% visit with relatives. A family member was present in 87% of CRO members' social networks. The mean number of family members found in CRO member's social networks is 3.70 ($SD = 4.65$). Approximately 53% of CRO members reported the presence of at least one child in their social network ($M = 1.57$, $SD = 3.01$).

The largest single component in participants' social networks is constituted by other CRO members with 88% of participants noting the existence of at least one CRO member with whom they experienced a close relationship. Non-CRO friends were represented in 67% of CRO members' social networks, professional healthcare providers in 75% of these network configurations.

Thirty-one percent of CRO members' social networks included a least one co-worker. Other domains outside of the mental health system were also represented. For example, 49% of members' networks contained fellow church members. Also, 45% of CRO members reported individuals with whom they

Table 2. Frequency and Means of CRO Member's Service Utilization

	Times used in past 60 days					
	Not used	1	2-3	4 or greater	*M*	*SD*
Psychological						
Overnight hospitalization	94.70% (*n* = 125)	1.52% (*n* = 2)	0.76% (*n* = 1)	3.03% (*n* = 4)	0.31	(1.65)
Daytime treatment	85.61% (*n* = 113)	2.27% (*n* = 3)	2.27% (*n* = 3)	9.85% (*n* = 13)	2.20	(8.51)
Met with counselor	37.88% (*n* = 50)	17.42% (*n* = 23)	16.67% (*n* = 22)	28.03% (*n* = 37)	4.06	(9.46)
Case management	34.85% (*n* = 46)	5.30% (*n* = 7)	11.36% (*n* = 15)	48.48% (*n* =64)	5.42	(8.73)
Peer Support						
Peer counseling	81.06% (*n* = 107)	4.55% (*n* = 6)	4.55% (*n* = 6)	9.85% (*n* = 13)	2.33	(8.52)
MI support group	76.52% (*n* = 101)	2.27% (*n* = 3)	1.52% (*n* = 2)	19.70% (*n* = 26)	2.33	(6.09)
Drug/Alcohol						
Received detox	97.73% (*n* = 129)	0.76% (*n* = 1)	0.76% (*n* = 1)	0.76% (*n* = 1)	0.80	(1.15)
Sobering program	97.73% (*n* = 129)	0.00% (*n* = 0)	0.76% (*n* = 1)	1.52% (*n* = 2)	0.80	(7.91)
Received counseling	95.45% (*n* = 126)	1.52% (*n* = 2)	1.52% (*n* = 2)	1.52% (*n* = 2)	0.12	(0.67)
AA/NA meetings	93.94% (*n* = 124)	0.00% (*n* = 0)	1.52% (*n* = 2)	4.55% (*n* = 6)	0.12	(6.85)
Physical						
Overnight hospital stay	90.91% (*n* = 120)	3.03% (*n* = 4)	1.52% (*n* = 0)	4.55% (*n* = 6)	0.56	(2.99)
Emergency room visit	82.58% (*n* = 109)	9.09% (*n* = 12)	6.06% (*n* = 5)	2.27% (*n* = 3)	0.52	(2.70)
Visited doctor or nurse	52.57% (*n* = 69)	20.45% (*n* = 27)	14.39% (*n* = 10)	12.88% (*n* = 17)	2.13	(6.45)

participated in recreation or hobbies (e.g., fishing, crafts). Classmates were present in about 19% of CRO members' networks. Data are presented in Table 3.

Member Involvement

About 22% of CRO participants had been members for less than one year, 14% for 1 to 2 years, 25% for 2 to 5 years, and 18% for ten or more years. The mean number of years attending a CRO is 4.69 (*SD* = 5.0). Data on years of membership appear in Table 4.

For 20% of CRO members, a CRO was the only mental health support used during the 60 days before interview. The highest percentage of members, about 23%, attended their CRO 2 days per week or more, with 5% attending daily. The average attendance of CRO members is 3.39 (*SD* = 1.75) days per week. The frequency of days of CRO attendance is presented in Table 5.

Visits of less than 1 hour were reported by 1% of CRO members. Over 25% of CRO members spend between 6 and 7 hours per visit, average 4.51 (*SD* = 1.83) hours.

CRO Member Demographics

The gender composition of CRO members was about 50/50% (*n* = 65 females; *n* = 66 males). Race/ethnicity was 73% Caucasian, 14% African American, 1% Asian, 5% American Indian, 4% Spanish/Hispanic, and 4% other ethnic/racial groups. At the time of the survey, approximately 14% of CRO members reported

Table 3. CRO Member Social Network Composition

Network member	Percent of network	*M*	*SD*
Spouses, significant others	2.18%	0.58	0.64
Children	5.85%	1.57	3.01
Family members	15.07%	4.04	6.16
CRO members	26.79%	7.18	14.41
Employment-related	6.02%	1.61	4.89
Professional health providers	7.60%	2.04	3.77
Religion related	13.68%	3.67	11.63
Recreational related	6.39%	1.71	3.80
School related	3.22%	0.86	4.56
Friends	10.77%	2.89	5.74
Other	2.43%	0.65	2.99

Table 4. Years of CRO Membership

Years	Frequency	*N*
Less than 1 year	22.00%	29
1 to 2 years	14.39%	19
2 to 3 years	10.61%	14
3 to 4 years	10.61%	14
4 to 5 years	4.55%	6
5 to 10 years	19.70%	26
Over 10 years	18.21%	24

Table 5. Frequency per Week Attending CRO

Time at CRO	Frequency (*N* = 132)	*N*
Less than weekly	6.06%	8
1 day per week	5.30%	7
2 days per week	22.73%	30
3 days per week	19.70%	26
4 days per week	15.91%	21
5 days per week	21.21%	28
6 days per week	3.79%	5
7 days per week	5.30%	7

being married or living with a significant other, 49% were single/never married, nearly 35% were separated or divorced, and 2% widowed.

During the 12 months prior to the interview, nearly two-thirds reported that they were disabled. Thirty-two percent had worked for pay, with the average number of hours in the past 30 days 45.55 (*SD* = 40.91). On average, employed CRO members earned $7.56 per hour (*SD* = 2.71). Volunteering regularly at various organizations (including their own CRO) was reported by nearly 29%. Further information regarding CRO member demographics appears in Table 6.

Table 6. CRO Member Demographics

Time at CRO	Frequency	*N*
Gender (*N* = 131)		
Male	50.80%	66
Female	49.20%	65
Ethnicity (*N* = 132)		
Caucasian	72.73%	96
African American	14.39%	19
Asian/Pacific Islander	0.76%	1
American Indian/Alaskan	4.55%	6
Spanish/Hispanic	3.79%	5
Other	3.79%	5
Marital Status		
Married or cohabitating	14.39%	19
Single (never married)	48.48%	64
Separated, divorced	34.85%	46
Widowed	2.27%	3
Employment/Volunteer Status[a]		
Disability	62.12%	82
Worked for pay	31.81%	42
Unemployed	5.30%	7
Student	1.52%	2
Retired	1.52%	2
Homemaker	1.52%	2
Military service	0.76%	1
Controlled environment	0.76%	1
Volunteer[b]	28.79%	38

[a]Employment statuses are not mutually exclusive thus frequencies do not sum to 100%.
[b]In addition to other employment statuses.

DISCUSSION

Service Utilization

Though most CRO members receive some form of psychological services, few require the use of day treatment and even fewer experienced hospitalization. Participation in a CRO is believed to contribute to lower rates of hospitalization as reported by CRO members (Nelson et al., 2006b; Trainor et al., 1997).

Many CRO members do not receive counseling from either professionals or peers. This may suggest that the informal peer support of the CRO setting provides benefits that complement and reduce the need for traditional professional mental

health services. The most disturbing finding relates to the high level of use of medical services for physical illness. Severe physical health issues and lack of adequate treatment are common among mental health consumers, and may represent the largest health disparity in the United States (Osborn, 2001).

Patterns of Social Interaction Related to CRO Relationships

Some CRO members reported having relatively balanced social networks of family, members of their CRO, and people not associated with a CRO or the mental health system. As past research has shown (Corrigan & Phelan, 2004) the social networks of adult consumers is less influenced by a spouse or significant other or by children and extended family.

Church friends contributed almost as much to CRO member's social network as did family members. Similar to a non-psychiatric population of middle-age persons we find only a small percentage of CRO members who are attending school. The contribution of work friends and acquaintances tied to recreation also is quite small as CRO members spend less time in these activities than same age adults who are not consumers.

Though found to be somewhat lower than in previous studies, other CRO members composed the single largest part of CRO members' social networks. When combined with non-CRO friends with psychiatric illness and mental health providers, participants' social networks are dominated by persons in the mental health system. The roles of executive directors, staff, board members, and others deeply involved in their CRO provide a greater amount of social interaction for non-consumers, which could account for lower dominance of CRO members in their social networks.

Additional research is needed to compare the social network of CRO members to those who do not participate in a CRO. More deeply examining the characteristics of CRO members who "grow" a more balanced social network is also worthy of additional research with the expectation that social integration can contribute greatly to meaningful psychological and physical integration. Further, it would be of interest to compare these social networks to those of non-consumer populations of similar SES and age to determine the comparative balance in social networks.

In addition to the diversity provided by persons who are not consumers, the diversity that exists among members may provide impetus for growth. The case also may be made that the importance of diverse social networks is mitigated because of the benefits provided by the supportive setting of a CRO.

Member Involvement

A majority of members attend their CRO several days a week, many members thus maintaining involvement in their CRO. Most members spend more than 3 hours at their CRO in each visit. However, most members depend upon their

CRO for transportation both to and from the organization, making it difficult to specify actual visit duration.

CRO Member Demographics

The literature is mixed in findings that provide data on the characteristics of those who attend CROs. An equal number of men and women participated in the eight CROs included in this study, which is generally assessed to be representative of the population of active members within the 25 CROs in Kansas. While the CROs in this research attracted men and women equally 25 women are frequently found to be more attracted to self-help groups than men, excepting AA and other anonymous addiction groups.

A larger number of minority members of CROs was noted in this study (27%) compared to the ethnic and racial composition of the psychiatric disabled population in Kansas as a whole (19%). It is difficult to ascertain how this compares to other self-help groups and organizations because demographics are partially based on local community factors. At the same time the racial makeup of these eight CROs is similar to the general population of subject areas.

The diversity of CROs indicates that CROs are attracting more persons of color than other mental health settings. This may be associated with peer support as central to CROs, based on the powerful commonality of working toward recovery. The setting of the CRO allows the process of recovery to take place in a holistic manner that empowers individuals to feel a sense of control over their illness regardless of gender or race.

The low percent of CRO members currently or ever married is similar to what has been found previously in CRO research and in research on psychiatric populations, demonstrating the difficulty that psychiatric illness presents in maintaining relationships. CROs provide a setting that allows new and lasting relations to develop which provide greater mutual understanding of the disruptive impact of mental illness on relationships, while creating opportunity for more effectively navigating resulting complex situations.

The majority of CRO members were disabled and only 32% were employed, mostly part-time. CROs attract those whose life has been severely impacted by mental illness and dominated by those served by the public mental health system. At the same time, CROs provide jobs available only to consumers, opportunity to serve on a non-profit board made up of only consumers, volunteer activities, and access to similar opportunities outside the CRO. Further, as the number of certified peer specialists grows, many of these jobs will be filled by those who gained job and volunteer experience in CROs.

Limitations

The ability to generalize the findings of this study is limited by the sample as previously described. Although inclusion of more CROs would provide a greater

degree to which findings could be generalized within Kansas, it would not allow generalization nationally or globally. The number of persons of color in the sample was not large enough to allow accurate analysis by ethnicity.

The measures utilized in this study relied on self-report and are susceptible to the effects of social desirability. Three strategies were used to help address this issue. First, it was emphasized that the purpose of the interview was to understand the participant's own experiences as a mental health consumer. Second, it was emphasized that there were no "right" or "wrong" answers. Third, researchers reminded participants that all answers were confidential and would not be seen by anyone outside the research team.

Another possible limitation is associated with the fact that some questions required members to recall the frequency of various actions (e.g., visiting the doctor), which may have affected the accuracy of data collected. One strategy to address this involved asking participants to consult their appointment book, if they had one—itself a possible biasing factor. Another strategy focused on breaking longer periods into several shorter ones and summing the frequencies (e.g., 1 month broken into weeks). In addition, inclusion of measures on age, education, and other socioeconomic data would have added depth to the findings. Lastly, there is no parametric information available for the measures used in this study. However, many measures were chosen because of their previous use in national research projects relevant to the present study.

Future Direction

Future research would benefit by creation of a sample of consumers representing members of CROs outside Kansas. Although the sample of this study apparently properly reflects the population of mental health consumers in this area, a larger sample of persons of color is required if we are to understand how CROs can attract and maintain members of underserved populations.

If CROs and their effects on members are to be understood, it will be necessary in future research to utilize a research design that allows the measurement of member outcomes. Additionally, research is needed to explore details relating to members' social networks, and the effects of these networks on livelihood and integration within the larger the community.

CONCLUSION

CROs allow members to give and receive help and to experience greater diversity than that found in the traditional mental health service system. CRO members provide support for one another and utilize professional mental health services based on need beyond habit or dependence. CRO members are dedicated to their recovery and importantly to the recovery of their peers, as shown by higher number of years in membership and the amount of time spent at the CRO.

We propose that CROs and other consumer-operated services are of critical significance for the future of the mental health system. The proliferation of mutual support organizations as well as the reimbursement for certified peer specialists by Medicaid makes this inevitably evident. It is in this spirit that Pat DeLeon, past president of American Psychological Association (APA) state, "The future for psychology is getting involved in what most psychologists aren't being trained to think about: helping [clients] really control their own destiny" (Cynkar, 2007, p. 31).

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