Consumer-Operated Drop-In Centers: Evaluation of Operations and Impact

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Abstract

Research on self-help for consumers of psychiatric services has focused on the operation of voluntary groups and largely ignored service programs operated by consumers. This evaluation study focused on six consumer-operated drop-in centers, each established for at least two years. These centers served a combined total of 1,445 consumers and were funded as demonstration projects by the Michigan Department of Mental Health. Structured interviews of consumer-users of these centers indicated that the program was meeting its funding intents of serving people with serious mental illness and of creating an environment promoting social support and shared problem solving. Levels of satisfaction were uniformly high; there were few differences across centers. Issues that emerged for future policy and research considerations included funding constraints, enhancing accessibility (particularly for women and people needing frequent hospitalization), variable levels of support from catchment area community mental health agencies, and determining the long-term benefits of drop-in center participation.

Introduction

The self-help movement had its origins in the United States in the 1930s.[1] Although the first self-help group for former psychiatric patients was formed more than 50 years ago,[2] recognition of this approach as a significant alternative or adjunct to traditional mental health treatment is of relatively recent origin — especially in comparison to its use with other "problem" groups, such as people with substance abuse or with chronic medical conditions. Consumers have consistently advocated not only for establishment and increased visibility of mutual-support groups for individuals with serious mental illness, but for consumer-controlled and -operated services.[3-5]

Research on self-help approaches for individuals with long-term mental illness lags far behind advocacy for and even operation of such programs. What research exists is mostly of a descriptive nature, for example, presenting and typing various self-help approaches,[2,6] describing members of self-help groups,[7] or how mental health professionals feel about or interact with mutual support groups for psychiatric clients.[8,9] A few studies have examined operations of self-help groups in-depth, e.g., what goes on in meetings,[10] expansion strategies,[11] or how mutual help groups differ from psychotherapy groups.[12]

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Studies reflecting any awareness that self-help approaches for psychiatric clients may encompass more than meeting in groups are limited. Church[13] discussed three types of "user involvement" in mental health services. A few other studies have provided descriptive information on the programmatic intent and operations of a variety of consumer-operated service initiatives.[14-16]

The paucity of descriptive data on consumer-operated interventions and the lack of evaluation activity in this area may not be surprising, given the challenges often confronted by research on self-help and mutual support. The long-standing tension between psychiatric consumer organizations and professionals may provoke suspicion or lack of cooperation in evaluation activities, unless the consumer group is a full partner in the design and execution of such studies.

This report seeks to enhance the knowledge base on self-help approaches for individuals with serious mental illness by presenting research on a consumer-operated service alternative — the drop-in center. The Michigan Department of Mental Health has led the nation in investing in this type of service approach through a demonstration project model.[14] The current study involves six drop-in centers that are run exclusively by psychiatric consumer groups. The research goes beyond describing the centers to carrying out a process evaluation, focusing on the extent to which the centers met programmatic expectations, collecting retrospective satisfaction and impact assessments from participants, and examining differences in operations across the six centers. This evaluation research study represented a collaborative undertaking between the Michigan Department of Mental Health, a major state university, and a statewide psychiatric consumer organization.

Setting

Since the early 1980s, a self-help group called the Justice in Mental Health Organization (JIMHO) has received Michigan Department of Mental Health (DMH) funding to assist consumers of mental health services to start and operate drop-in centers in various cities in Michigan. A drop-in center, as defined by JIMHO, is "a place which provides a critical social support function for high-risk hospital users with both organized and informal recreational and social activities where individuals and center staff assist each other in solving their social, recreational, housing, transportation and vocational problems." The state's intent in funding these centers is to provide an alternative or adjunct to traditional mental health services for people with serious mental illness, which meets four contractual objectives: (1) to provide a safe, supportive, and normalizing community environment for persons with mental illness who are isolated in society; (2) to provide an atmosphere of acceptance; (3) to help such individuals feel needed and grow in self-worth, dignity, and respect; and (4) to increase knowledge about the community by learning from one another. Emphasis is placed on developing individual autonomy and decision-making, and utilizing peer group assistance and natural support systems. The centers are basically run by the consumers without involvement of mental health professionals. Each center is a nonprofit, private corporation, with a board of directors.

The study reported in this paper was conducted by the Michigan Department of Mental Health in cooperation with JIMHO and Michigan State University. The objectives of the study were as follows: (1) to gather descriptive information on consumer-operated drop-in centers, (2) to survey individual consumer's perceptions and evaluations of the center, (3) to determine similarities and differences among the centers, and (4) to establish the relationship between these similarities and differences and other factors including attendance and consumer satisfaction with the drop-in center.

The study included six drop-in centers that had been in operation at least two years (12 are operated through JIMHO). All six centers are located in mixed business and residential neighborhoods in urban areas across Michigan, operating from 35 to 56 hours a week. Approximately 1,445 consumers, or an average of 241 consumers per center, utilized the centers during 1990. The average annual budget of each center is $30,000. Paid staff is limited to a center director, and in some centers, an assistant director. The directors, board members, and volunteers are all mental health consumers.

Methodology

A three-person research team from the Michigan Department of Mental Health and Michigan State University worked with JIMHO personnel and two drop-in center directors in planning the project, developing the instruments, and setting up the interviews.

Instrumentation

The interview instrument developed and utilized for the study consisted of nine sections covering demographic and mental health service utilization information, consumer likes and dislikes about the center, problems regarding center utilization, social environment rating, member assessment of each center's effect on their lives, and member satisfaction. The instrument was designed to collect information on whether the drop-in centers' objectives and DMH funding intents were being met.

The Social Environment section was patterned after Moos and Humphrey's Group Environment Scale (GES)[17] and Moos' Community Oriented Programs Environment Scale (COPES).[18] The measure included only GES and COPES items deemed appropriate for the drop-in center environment, such as items measuring cohesion, intimacy, and independence; other items were constructed by the researchers. All items were subjected to factor analyses and to reliability analyses. Factor analysis revealed five factors, which subsequently were the bases for constructing four subscales, with the last factor consisting of only one item. The scales utilized were as follows: Group support and mutual learning (8 items, Cronbach's $\alpha = .81$), Intimacy and sharing (5 items, $\alpha = .70$), Release of frustration and anger (2 items, $\alpha = .68$), Personal freedom (2 items, $\alpha = .43$), and Ability to complain (1 item).

The section on members' satisfaction consisted mainly of items on a four-point scale adapted from Nguyen, Atkisson and Stegner's Client Satisfaction Questionnaire (CSQ-8).[19] The CSQ-8 is a standardized instrument with excellent reliability and validity indices measuring client satisfaction with mental health services. In this study, a four-item version of the CSQ-8 attained a Cronbach's α of .68.

Data Collection

The data collection period lasted six weeks. Twenty interviews were targeted for each center. To the extent feasible, all members who were present at the drop-in center during the interview days were requested to participate. The refusal rate was 7%. Interviews were conducted only after participants gave their voluntary consent. The interviews were based upon the prepared questionnaire and were completed in an average of 25 minutes.

Participants

From the six centers, 120 mental health consumers were interviewed; 38% of the participants were women. The majority (68%) were white, while 29% were African-American and 3% were from other minority groups. Consumers ranged in age from 17 to 69 years, with an average age of 36.7 years. Eighty-two percent had been hospitalized at least once for mental health reasons, and most consumers had used mental health services at some time: 53.3% case management, 30.0% medication clinic, 17.5% day treatment, 12.5% assertive community treatment, and 8.3% group homes (responses were not independent). Only 9% of the respondents had never used any formal mental health services.

Almost half of the respondents (48%) had been coming to their centers for more than two years while only 15% had been in attendance less than six months. The majority of consumers interviewed walked to the center (59%) and came at least once a week (93%); 48% came every day.

Results

Perception and Evaluation of Centers by Members

Participants were asked a number of open-ended questions concerning their reasons for coming to the center, perceived similarity to CMH services, dislikes at each center, and problems in center utilization.

Social support emerged as the dominant reason consumers used the drop-in centers. The majority of the respondents (53.3%) reported coming to the center for people-related reasons such as having friends there, a sense of family, or the chance to socialize, converse, and exchange ideas. Other reasons consumers came to the center were: something to do (25.0%), a place to go (e.g., away from the streets, 23.3%), responsibility as a volunteer or worker at the center (19.1%), relaxation (14.2%), for coffee and doughnuts (13.3%), getting help and encouragement (6.7%), or other reasons (4.2%).

Respondents were also asked questions related to the intent of the consumer-operated drop-in centers. The majority of respondents (87%) believed that the members decide what to do at the center, in contrast to only 13% who thought other people, such as the director or board members, decide the activities. The majority (58%) also perceived that the center belonged to the people. Almost everybody felt accepted at the center (99%). In addition, 98% came to the center of their own free will (versus feeling forced to come by CMH staff or some other external force).

When asked what they disliked about the center, 45% of the respondents could not think of anything. Others (25.8%) cited disliking specific individuals or behaviors (e.g., trouble-makers, anger and arguments, borrowing of cigarettes, filthy language, unhygienic practices, apathy, lack of cooperation, people with problems). Some participants (5.8%) cited the environments of the centers (e.g., smoky air, old furniture). Others (5.0%) disliked not having enough options and activities to do. Still others mentioned miscellaneous rules (5.0%) or behaviors of staff or board members (3.3%).

Suggestions for changes at the centers included more activities (e.g., field trips, having television sets, or pool tables, 21.7%), improvements in the physical environment (e.g., having nonsmoking areas, cleaner places or new furniture, 17.5%), and rule, policy or practice changes (e.g., rule enforcement, more open board meetings, having a suggestion box, a schedule for the use of the television, 15.8%). Others suggested the following: being open longer hours and/or on Saturday (11.7%); changes in food-related services such as free lunches, better coffee and food quality, or more varied snacks (11.7%); more peer-based helping activities (5.0%); and changes in specific behaviors (5.0%).

Although only 5% desired transportation assistance as a change, when asked specifically about problems in getting to the center, 17.5% mentioned transportation — either in general (5.6%), lacking the money for bus fares (6.3%), unavailability in winter (2.8%), or unavailability on weekend/specific routes (2.8%).

There were significant gender differences ($\chi^2 = 13.18$, df = 3, $p < .01$) in how members got to the center. Seventy-two percent of the men interviewed walked to the center, and only 8% rode the bus. In contrast, only 39% of the women walked, while 20% used the bus. Transportation difficulties were also significantly related to attendance at the center ($\chi^2 = 16.64$, df = 3, $p < .01$). Ninety-one percent of those who came at least three days a week had no transportation problems.

Concerning the desired overall changes, most respondents felt that they could help bring them about. Among the 18% who felt powerless to do anything, women were overrepresented ($\chi^2 = 8.64$, df = 2, $p < .02$), as were consumers who had been hospitalized at least once ($\chi^2 = 7.72$, df = 2, $p < .03$).

Vis-a-vis their similarity to CMH services, the drop-in centers were perceived by 77% of consumers to differ positively from other mental health programs they had experienced. The major differences cited were more freedom (29.2%), more support and caring (21.7%), and less structure (11.7%). Less than 3% of respondents rated other mental health programs more favorably, such as having

Table 1
Social Environment Subscale Scores

Subscale	*N*	Mean	Std. Dev.	Possible Range	Actual Range
Group Support and Mutual Learning	108	26.55	5.11	8–32	9–32
Intimacy and Sharing	115	17.94	2.62	5–20	6–20
Release of Frustration, Anger	118	5.14	2.20	2–8	2–8
Personal Freedom	117	6.33	1.73	2–8	2–8
Ability to Complain	115	2.96	1.18	1–4	1–4

better trained staff. Twenty-one percent of the respondents perceived the centers as similar to other mental health programs, e.g., in functions, activities, people and/or environment. In a related question, only 11% reported ever feeling pressured to do something at the center (e.g., for conformity, to give rides).

Social Environment Assessment

Participants were also asked a series of closed-response questions concerning the perceived social environment of each center. Table 1 summarizes the results, where higher scores reflect a positive assessment.

The Group Support and Mutual Learning average score indicates that people at the center were perceived to support and help, and subsequently learn from, each other. The average score on Intimacy and Sharing reveals that most people at the center felt close and intimate with each other, felt able to be themselves, and to share their thoughts and feelings. However, respondents who had been hospitalized and/or who had utilized community mental health services generally reported less intimacy and sharing than those who had not used these services ($t = 3.61, p < .01$ and $t = 2.89, p < .01$, respectively). From results on the Release of Frustrations and Anger scale, most respondents believed that people cannot just come in and release their emotions anytime. For example, in certain situations, display of anger was not permitted. The score on the Personal Freedom scale shows that respondents believed members are encouraged to make their own decisions and do what they want at the center. According to the average score on the Ability to Complain item, most respondents did not feel that it is just OK for them to complain anytime.

Effect of Center on Members

Members were asked how the drop-in centers had affected their lives. Participants were given an open-ended question concerning their activities before they started coming to the center versus their current status (see Table 2). In general, increases were reported in the more positive activities such as volunteer work, job, or school, and decreases reported in institutionalization and unhealthy activities like drug or alcohol abuse, or "running around in the streets." Decreases were also reported in the use of CMH services.

Positive effects were also noted when respondents were asked how the center had changed their lives. Seventy-nine percent of respondents reported gaining more friends through the center; 53% reported being more confident in making recent decisions in employment, education, living conditions, relationships, treatment, or other life changes. Most respondents (72%) attributed the increase

Table 2
Ways of Spending Time in the Past and Currently

	Before		Now		Difference	
Activity	*N*	%	*N*	%	*N*	%
Coming to drop-in center	0	0.0	87	72.5	87	100.0
Volunteer work/job	32	26.7	39	32.5	7	21.9
Socializing with friends	25	20.8	26	21.7	1	40
School	2	1.7	5	4.2	3	150.0
Non-CMH support groups	3	2.5	5	4.2	2	66.7
MH program/other center	23	19.2	9	7.5	–14	–60.9
At home	44	36.7	40	33.3	–4	–9.1
Solitary activity outside	31	25.8	23	19.2	–8	–25.8
Prison/hospital	6	5.0	0	0.0	–6	–100.0
Unhealthy activities	6	5.0	2	1.7	–4	–66.7
Sports/games	6	5.0	4	3.3	–2	–33.3
Church	2	1.7	1	0.8	–1	–50.0
Other responses	5	4.2	2	1.7	–3	–60.0
Total $N = 120$						

in confidence to factors related to the center such as the support from people (48%), being helped by the center (16%), having responsibility at the center (6%), and/or seeing other people at the center improve (3%). An additional effect of the center perceived by participants was its contribution to decreased hospitalization. Sixty-eight percent believed the center had helped them stay out of the hospital, in contrast to 19% who expressed a contrary opinion. Thus, retrospectively, a majority of the respondents reported positive impacts from center participation on many aspects of their lives.

Satisfaction with the Center and Its Predictors

The Satisfaction scale assesses the extent to which the center meets members' needs for friendship and support, helps them cope better with problems, how pleasant the physical environment is, and how satisfied they are with the center. Scale scores can range from 4 to 16 (with 16 indicating great satisfaction). Thus, the average satisfaction score of 12.94 (standard deviation, 2.08) indicates respondents were generally satisfied with the center and felt it met their social needs. Almost all the respondents (95%) would recommend the center to other mental health consumers.

The level of satisfaction with the center was significantly related to several variables (see Table 3). Greater satisfaction was expressed by respondents who also reported feeling they could help bring about change at their center, never feeling pressured at the center, gaining friends through the center, feeling more confident in making decisions, and that the center helped them stay out of the hospital. Those who came to the center everyday also expressed greater satisfaction with the center than those who came less frequently. Satisfaction with the center was also significantly related to scores on two Social Environment scales: Group Support and Mutual Learning, and Intimacy and Sharing. Those who perceived the center as generally supportive and helpful, and a place where they could feel close to people and share their thoughts and feelings, generally expressed greater satisfaction with the center.

The above variables and others which would logically be related to satisfaction were the independent variables in multiple regression analyses to identify factors most useful for predicting satisfac-

Table 3
Significant Relationships with Satisfaction

Variable	Statistic	*N*
Feeling able to help bring change	$t = 2.90^b$	86
No experience of being pressured	$t = 2.24^a$	114
Gaining friends through the center	$t = 3.69^b$	112
Spending time outside with friends from the center	$t = 2.92^b$	115
Increased confidence in decision making	$F = 7.44^b$	115
Believing center helped decrease hospitalization	$t = 3.75^b$	102
Greater frequency in coming to center	$F = 3.67^a$	115
Believing staff/director decide what people do at center	$t = 2.80^b$	116
Group Support and Mutual Learning score	$r = 0.49^b$	100
Intimacy and Sharing scale score	$r = 0.41^b$	100

[a] $p < .05$. [b] $p < .01$.

tion. Results indicate that the Group Support and Mutual Learning scale score is the best predictor of satisfaction, at least among the variables in the study. Additional significant predictors include beliefs that the center had helped him/her stay out of the hospital and helped improve confidence in decision-making, and whether he/she comes everyday. Together, these four factors explain 38.4% of the variability in the satisfaction score. Other variables explain very little of the remaining variability.

Satisfaction with each center was apparently not influenced by consumers' evaluation of its physical environment. The average rating of the physical environment showed that the majority of respondents found the centers' environments generally pleasant. Though 8% of the respondents considered the centers unpleasant, these consumers were still satisfied.

Differences among the Centers

There were no significant differences among the centers in the number of men versus women members. The centers, however, differed significantly in the ages of the respondents ($F = 2.69$, $p < .03$) and in racial composition ($\chi^2 = 22.27$, df = 10, $p < .02$). Average ages of the consumers in the different centers ranged from 33.05 to 44.28 years. Percentage of minority members varied from 19% to 52.6%. Age and race differences were not reflective of geographical locations. Apparently, some centers have more diverse membership than others.

Centers also differed significantly in community mental health service utilization by their members ($\chi^2 = 30.22$, df = 5, $p < 0.01$). In several centers, most respondents availed themselves of local CMH services, while only half of those in one center had done so. No significant differences among the centers existed, however, in the hospitalization histories of their members.

The length of time that respondents have been coming also varied among the centers ($\chi^2 = 50.53$, df = 15, $p < 0.01$), but the frequency of coming did not. While the majority of the members in some centers have been coming for more than two years, other centers had most members coming for a year or less.

Transportation was considered a problem by at least one-fifth of the respondents in four centers, while only 5% or less indicated this in other centers.

Overall, members first heard about the center through word of mouth, such as from friends or acquaintances (36%), from CMH or foster care home staff (31%), or from drop-in center directors or board members (21%). There were significant differences, however, among the centers (χ^2 =49.14, df = 30, $p < 0.02$). While 63% of the respondents in one center heard about the center first from friends or acquaintances, only 10% from another center did so. Reporting the local community mental health agency as the first source of information about the center ranged from only 5% of respondents in one center to 39% in another.

The centers also differed significantly on two out of the five subscales of the Social Environment assessment: Intimacy and Sharing ($F = 3.15$, $p < .02$) and Personal Freedom ($F = 2.68$, $p < .03$). Average Intimacy and Sharing scale scores for each center ranged from 16.52 to 19.33, while the average Personal Freedom scale score per center ranged from 5.29 to 7.11. Although all centers were generally perceived by the respondents to facilitate closeness and sharing among the members, and to encourage freedom and making their own decisions, two centers led in these qualities. The social environment at one center, on the other hand, was perceived to be less encouraging of individual freedom and less conducive for intimate sharing.

Although there were differences among the centers on some dimensions assessing the social environment, the respondents were generally equally satisfied with the various centers. However, centers differed in what the respondents disliked about them (χ^2 = 100.08, df = 65, $p < 0.01$). A high 74% of the respondents in one center, in contrast to 30–45% of respondents in others, could not report anything they disliked about their center. More than 25% in three centers cited certain people or their behavior as what they disliked most; less than 10% in the other centers did so. All responses citing dislike of the center's location came from one center.

There were no significant differences among the centers in terms of the respondents' perceived increases in confidence in decision-making, decreases in hospitalization, and in the overall effect of the center on one's life. The centers, however, differed significantly on whether a member had gained more friends through the center (χ^2 = 21.83, df = 10, $p < .02$). At least 80% of the respondents from four centers believed they had more friends now, while no more than 68% indicated this in the other two centers.

Discussion

Evaluative Analysis

The results allow an analysis from the perspective of a process or implementation evaluation[20] as well as effectiveness.

Overall, the results indicate that the different centers are basically providing services as intended. Where significant differences among centers exist, they reflect their richness and diversity, but do not detract from the centers' main function. Thus, the major objectives of drop-in centers, to provide mutual support and acceptance and to increase knowledge of community resources, were found to be met in a uniform manner. The ability of drop-in centers to provide an environment that is safe, supportive, helpful, and normalizing for mental health consumers is evident in the themes of friendship, sharing, relaxation, personal freedom, and acceptance emerging from the responses to open-ended questions. Social Environment Assessment scores showed that most respondents: (1) perceived the people at the center as generally friendly, supportive, helpful, and proud of the group; (2) felt close and intimate with each other, and shared their thoughts and feelings; and (3) believed people are encouraged to make decisions on their own and have personal freedom at each center.

The data also indicated that the people benefiting from the centers are mainly the intended target group: mental health consumers, the vast majority of whom have hospitalization histories. The centers also fulfill another objective: to provide help and support for people who are seriously mentally ill but not currently involved with mental health services. A majority of respondents perceived the centers as different from the mental health system, as they were intended to be. Thus, the drop-in centers can play an important role for individuals who are seriously mentally ill in keeping them connected to their communities and to needed services rather than isolated from important support networks.

Concerning the consumer-operated intent of the centers, participants did recognize that the centers are their own. Most perceived that the center belongs to the people who use it, and the vast majority thought that the participants decide how they spend their time at the center. Almost everybody felt accepted at the center and came to the center of their own free will.

Effectiveness of the drop-in centers can only be indirectly assessed in this one-time only, descriptive study. According to Satisfaction scores, almost all members were satisfied with their centers and believed the center fulfills most of their social needs. Multiple regression analyses reveal that satisfaction with a center is largely the result of its positive social environment. Respondents' answers demonstrate the impacts that the drop-in centers have had on their lives: more being engaged in productive activities (work, school, support groups) and fewer in unhealthy or solitary endeavors compared to before they came to the centers. The majority reported gaining friends at the center and having more confidence in their own decision-making, as a result of help they received from people at the center. Of significance to the public mental health system is the large percentage who felt that their center helped them stay out of the hospital. This seems to be especially true for those who see the center as enabling them to release their frustration and anger and as providing more help and support, as well as having helped them cope with their problems. Overall, a great majority of respondents cite positive effects that their center has had on their lives — most often in terms of improving feelings about themselves, giving them something to do and providing social support. It may be concluded that the drop-in centers are operating as intended, with success, and deserve replication consideration in Michigan and in other locations.

Emergent Issues and Problems

Replications may benefit from attention to other results which may improve future program operations. The first concerns the limited resources that drop-in centers have to work with. The allocated $30,000 annual budget is minimal compared to CMH operations, as well as in meeting expenses necessary for its diverse objectives. Participants' responses to questions of dislikes and change suggestions reinforce this point. Requests for more activities, improvements in the physical environment, longer hours, and food-related services all require additional resources not within present budget capability. Replications of the consumer-operated drop-in center model should provide substantially increased funding.

Secondly, there is great variation in the length of time consumers have used these centers and in their frequency of utilization. Attendance is strongly related to the distance the person has to travel to get to the center. Transportation was mentioned as a problem for about one-fifth of the sample, especially women (who have to travel farther than men), those who have to take the bus, and those with a hospitalization history. Thus, it can be implied that drop-in center replications should focus on improving transportation availability with particular attention to members with greater transportation problems.

Another access issue concerns referrals to consumer-operated drop-in centers. Overall, only about one-quarter of the respondents indicated they had heard about their centers from community mental health staff, and there was a significant difference across centers on this question. Perhaps staff in some CMH agencies are unaware of or have a negative image of the drop-in center and therefore do not suggest it as an activity or support to their clients. For example, Lieberman et al.[16] found that case managers only referred clients to a peer support program at the client's request. CMH agencies need to encourage staff to provide referrals and support to existing clients for attending. This encouragement may be particularly important for two subpopulations that demonstrate more problems in their involvement, specifically, women and people with psychiatric hospitalization histories. Drop-in centers obviously cannot provide extensive consumer benefits unless they are widely used.

Results indicated significant differences among the drop-in centers on some variables, notably on the Social Environment scales of Intimacy and Sharing and of Personal Freedom, and in the percentage of respondents indicating some areas of dislike. Respondents perceive some centers as less encouraging of individual freedom and less conducive for intimate sharing. It is encouraging to note that on variables reflecting social support, ownership, and perceived positive outcomes, there were no across-center differences. These differences imply that even with a defined model and technical assistance availability, differences in implementation across sites may inevitably occur. When replicated, researchers need to ensure that adequate evaluative information is collected on operations and satisfaction so as to identify these differences and provide additional consultation to those centers with less favorable outcomes.

Limitations and Future Directions

Limitations in study sampling and design may influence results; for example, whether the study's sample is representative of the center's intended beneficiaries. As people are free to choose to come to the center or not, the sample for the study, composed of people who were at the center at the time of the interviews, may be a select sample biased in favor of the center. Thus, mental health consumers who have had problems with the center, have had restrictions placed on their use of the center, or dislike the center were less likely to be in attendance and be interviewed. These factors may account for the very few cases of people who expressed dissatisfactions. However, the sample does serve the purposes of the present study vis-a-vis opinions of center users. The limitation imposed by the sample's representativeness only restricts the generalizability of the results of the study to the greater population of potential users of drop-in centers.

The design of the current study might also be seen as a limitation, in that no comparison or control groups were utilized. However, given a limited knowledge of self-help and consumer-operated programs, this level of data collection appears appropriate. That is, following the evaluation framework presented by Chen,[20] evaluators should first address whether programs are serving target beneficiaries, with service delivery activities and procedures as intended, and meeting their specified objectives. Once this is assured, experimental designs for outcome evaluation may be considered, but not before. Otherwise, it cannot be known whether unsuccessful outcomes reflect failure of the specified model or failure to implement the model, as specified.

Now that this process evaluation has demonstrated the feasibility of research on these consumer-operated initiatives and the fact that, for the most part, their implementation has been successful, additional steps in evaluation research should be undertaken. Subsequently, extended research should study the methods of drop-in centers to achieve operational objectives, the extent and impact of collaboration between the centers and the traditional mental health establishment, the long-term benefits of drop-in center participation to consumers, and what determines who among potential participants become involved and who does not, and for what reasons.

Conclusions

In interpreting these evaluation results, mental health professionals and policy-makers should keep several things in mind. Satisfaction with each consumer-operated drop-in center is largely the result of its positive social environment. What a drop-in center becomes is thus basically determined by the mental health consumers. This is what a consumer-operated center is all about: a center run by the consumers, for the consumers. What outsiders such as policy-makers can do is to facilitate and ensure the continuing operations of such centers through material resources and support. Ultimately, however, it is the mental health consumers themselves, both the members and the staff, who create and form the drop-in center and make it work.

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