Self-help Resource Centre (SHRC)

Review of Select Literature on Self-help/ Mutual Aid Use

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Introduction

As a not-for-profit organization, the Self-Help Resource Centre (SHRC) of Greater Toronto aims to promote mutual aid/self-help (MASH) through increasing its awareness and facilitating growth and development in the community and among helping professionals. In order to support these activities, SHRC required a general literature review on the process and effectiveness of MASH in the areas of health promotion, social capital and community building to discern the evidence that could support the use of MASH strategies. The literature review findings will be used to support SHRC to establish supporting evidence of MASH for the purpose of building a case for additional funding of its work, inform its strategies to support MASH activities as well as advocate for research in key areas of need.

Purpose and Scope of the Project

The literature review was of select research articles on the use, effectiveness and benefits of MASH strategies. As such, the objectives of the project were as follows:

1. To add to the evidence base knowledge for MASH strategies.
2. To organize the evidence of MASH strategies by relevant categories.
3. To identify the areas of gap where further research may be required.

Background

Definition

Mutual aid/self-help or MASH is variously defined in the literature and cover a broad spectrum of definitions ranging from those that are specifically defined, loosely defined to those that have a broad encompassing definition. There was, however, some consensus on several key elements of MASH definitions. These are described below as eight characteristics of MASH (Katz & Bender, 1976; Meyer et al, 2004):

1. A voluntary involvement without any coercion. Even those self-help groups that get formed in restrictive environment such as for people who are incarcerated and housed in prisons, there must be choice for the participant to be involved.
2. A coming together of people in a group structure. The size of groups was not particularly relevant nor was it particularly important that group members attended all established meetings. Additionally, groups could be open or closed. Open groups were those that allowed new members to join at anytime while closed groups had periodic openings at set times.
3. MASH groups convened mainly for the purpose of mutual assistance and accomplishment of special purposes. This could mean variously from satisfying a common need, overcoming a handicap or life-disrupting problem, to organizing group for a social economic enterprise or achieving social or personal change. The reasons for coming together were quite varied from group to group. The mutuality of need and reciprocity of support were key components where there was both a giving and receiving of some level of assistance.

4. Usually formed by peers although an initial onset may be triggered by professionals or professional agency or non-governmental organization, etc. Many MASH groups were supported by self-help advice centres during their founding months.
5. MASH groups were mostly led by group members and decisions tended to be made through consensus. Involvement of professionals or experts was a common feature in MASH groups in some countries (e.g. United States) more so than other countries (Germany).
6. There was an emphasis on face-to-face interactions amongst self-help group members. In this review, other forms of self-help such as internet, self-help books, etc were not included.
7. Members assumed personal responsibility for the group.
8. MASH promoted an ideology centered on personal and collective empowerment.

For the purpose of this project, MASH was defined as follows:

> Self-help/Mutual Aid refers to two or more people coming together as a result of a shared experience, problem or concern to address their issue and to bring about change through mutual support, sharing of knowledge and collaborative or co-operative action.

History

In the Euro-American context, the notion of self-help, self-reliance and mutual aid have been grounded in the tradition of Christian values and norms. These values have been central to foundation of Medieval Guilds which in many ways pre-modern examples of self-help groups. Interestingly, similar values have been around in other contexts throughout history. For example, the first recorded Guilds were found in India 3800 BC. Guilds were later followed by "friendly societies" to address the particular survival needs of poor people who were excluded from the exclusive arena of guilds and later more broadly for working class people (Kratz and Bender, 1976).

In the North American history, the tradition of self-help was rooted in the emergence of the early mutual aid societies or civil society as a form of social welfare that preceded organized governmental supports. Mutual aid societies were of particular help to the early settlers to protect themselves from the native population as there were being disposed and later to African American people in their quest to seek support and freedom from slavery. Mutual aid societies or more often referred as "benefit societies" also became prominent to address a whole range of supports including financial assistance or assistance to deal with illness, unemployment, retirement, arrival of a new baby, funeral expenses, etc. These benefit societies were often organized around geographic, ethnic, religious or occupational basis. Examples of mutual aid societies included trade unions, friendly societies, credit unions, fraternities, and self-help groups. The influence of these societies declined significantly as industry, health and welfare regulations came into prominence (Kratz and Bender, 1976).

The resurgence of self-help groups in the middle and later parts of the twentieth century has been noted as a response to the failure of assurance for inclusion, and the experiences of individuals to discrimination, stigma and marginalization but also the realization by professionals on the value of consumer involvement in meeting their own needs (Katz and Bender, 1976). A particular significant example for mutual aid occurred in concert with the immigration waves to North America, largely of peasants whose needs were not met elsewhere. Immigrant groups, therefore, established culture/ethnic specific mutual aid associations as a form of self-help. Many of these mutual aid groups have disappeared once the immigration levels decreased to a trickle.

Newer expressions of self-help groups emerged post World War II addressing special purpose needs such as issues of disability, mental health, addictions, eating disorders, bereavement as well as various chronic disease related self-help groups. Alcoholic Anonymous and other 12 step addictions groups have been cited as the most common special purpose self-help group currently existing in North America (Wituk et al, 2007).

It is difficult to know with accuracy the number and range of self-help groups that currently exist. MASH groups tend to be informal and are not required to register any where unless they choose to do so with umbrella organizations such as clearing houses and self-help advice centres, should these exist. MASH groups have differential life spans and may exist for short or long periods of time. Many groups such as self-help groups of the anonymous type prefer to maintain independence from organized structures or professionals (Meyer et al, 2004). Moreover, many groups do not request financial or other supports and do not necessarily advertise their presence (Matzat, 2001/02). Nonetheless, there have been attempts to quantify different types of self-help groups.

Meyer et al (2004) conducted a survey of 266 self-help advice centres in Germany to identify "psych self-help groups". They concluded that there are approximately 5000 such groups. In the United States, conservative report included estimates of 10 million member using self-help groups and possibly over 25 million using a group at some point in their life (Kessler et al, 1997). Gottlieb & Peters (1991) using Statistics Canada's Volunteer Activity Survey concluded that 2% of the adult population in Canada used self-help groups. Romeder (1993) using Statistics Canada's 1991 survey on aging and independence estimates that 4% of Canadians over the age of 45 participated in a self-help group. No recent data on self-help groups in Canada was found.

The acceptance and use of MASH as a formally acknowledge infrastructure varies widely around the world. Germany has perhaps the most sophisticated network of self-help groups and most recently MASH has been acknowledged as a legitimate component of the health and health promotion sector whereby self-help groups and recognized in the legislation and funding allocation to support the groups as well as self-help group advice centres and clearinghouses (Matzat, 2001/02). Matzat (2001/02) outlined several cautions on where Germany might be headed with its current trajectory of MASH. These included the professionalization of self-help with large self-help organizations that have many of the self-help functions performed by full time, paid staff and volunteers who have committed full time hours to the cause. There is concern that this movement might turn

into another form of service delivery and lose the essence of self-help. He stated, "It is not clear whether their involvement in the new field of self-help support will open the gates for self-help thinking, changing their professional medical or social work on a large scale, or will bind a new movement into a traditional system" (p. 319).

In the North American context, Wituk et al (2000) conducted a random sample survey of self-help groups in the state of Kansas. Out of a sample of 253 completed telephone interviews, they found groups focused on physical illness (38%), disability (11%), mental health (10%), addiction and eating disorders (8%), parenting (8%), and grief and bereavement (8%). They did not include alcohol and drug additions groups in their survey sample. Overall, they found that the groups varied greatly in their characteristics: length of group existence (average of 8 years), frequency of meetings, number of participants at meetings (average of 13 but range was from 2 to 50), etc. There were some common findings including the predominance of women participants (68%) and a minimum of participation of one meeting a month (94% of groups). A third of the groups (30%) met at least weekly. Surprising, a large number of groups were affiliated with professionals; albeit, in different capacities; e.g. leading groups (27%), shared leadership (11%), consultants (58%), referral sources (58%), sponsors (31%). Also, 57% of groups had a formal connection with a national self-help organization and 75% also had affiliation with a local organization or agency. There were differences between rural and urban based self-help groups with the rural ones being smaller, meeting less frequently and having greater challenges with attendance. The rural groups offered a greater degree of transportation support in order to bring members together for meetings.

Wituk et al (2000) also reported on various strategies that groups used to maintain membership such as word of mouth, newspaper listings, getting professionals to make referrals, distributing flyers, radio and television spots, outreach activities as well as creating welcoming and comforting atmosphere for newcomers to the group. Functions of the groups included emotional and social support (98%), information and education (96%), advocacy (58%), other goals (70%).

As self-help groups proliferated, self-help clearinghouses came into operation as a means to assist in a number of ways: assistance for new groups during their foundational period, referrals to self-help groups, space/facilities for meetings, technical consultation, creation of directories, newsletters, websites, workshops and training for facilitators as well as broad education about self-help to the public and networking among self-help groups. Many of the large cities in Canada currently have a self-help centre/clearinghouse. It should be noted, that some similar functions stated above are also conducted by community information lines, family resource centres, information lines specifically set up for parents of children with special needs and individuals such as social workers, public health nurses as well as hospital librarians and early intervention workers (MacAulay, 1995).

Benefits and Drawbacks

There are many potential benefits or positive outcomes from participation in MASH groups. Some of the common outcomes promoted by self-help groups include:

- Having opportunities to interact with others who have similar concerns – creating a sense of instant belonging or identity.
- Personal and collective empowerment.
- Expanding of one's social network and thereby creating an increased social capital.
- Acquisition of new knowledge and solutions to problems.
- Providing a basis for comparison.
- Collective action for advocacy, change and creating a new initiative.
- Alleviating loneliness and isolation.

Unfortunately, there is a dearth of research studies in the area of self-help groups and mutual aid and, where studies are available; these have not been adequately synthesized in order to determine the effectiveness of MASH groups (Meyer et al, 2004). The literature review below will provide some research based benefits from the limited research evidence that is available.

Drawbacks to self-help groups are also not adequately research-informed but are discussed in the broader literature as follows:

- Spread of myths or inaccurate information.
- Creation of confusion.
- Membership draws criteria and can create exclusion.
- Inability to sustain due to lack of formal channels and ongoing funding, etc
- Inappropriately used as a means of replacing expensive professional interventions.

Literature Review Methodology

To search the literature, a professional information specialist was engaged. The following research questions were used as broad guidelines for the search parameters:

1. What is the effectiveness of mutual aid/self-help strategies in the areas of health promotion, capacity development, empowerment and community building?
2. How cost effective are self-help strategies in supporting health promotion, capacity development, empowerment and community building?
3. Do self-help/care support groups/networks improve the clinical condition of the patients?
4. Do self-help/care support groups/networks benefit individuals and society?

The following parameters were used for the searches:

- 2000 to 2007
- Research articles
- Review
- Systematic review
- English or translated to English
- Global

The following databases were searched: Web of Science and Social Science Citation. Additionally, hand searches were conducted on the Internet as well as reference lists provided by various self-help clearinghouses.

Initial terminology used for the search included:

Primary Terminology:

- Self-help
- Self-help groups
- Peer support groups
- Peer-led groups
- Mutual aid
- Mutual aid group
- Mutual support group
- Self care network
- Self care groups
- Community network development

Secondary Terminology:

- Health promotion
- Chronic illness
- Mental health
- Community development
- Community building
- Empowerment
- Economic enhancement
- Healthy living
- Effectiveness
- Clinical effectiveness
- Cost benefit
- Social change
- Advocacy

See Appendix A for detailed search strategy. Over a hundred full articles were retrieved and reviewed. Key information from articles was extracted.

Findings

One hundred and two articles were retrieved and reviewed for this literature review. The articles were as follows (count is greater than 102 due to overlap in categories):

- Forty five (47) of the articles focused on mental health self-help groups;
- Eighteen (19) articles focused on chronic illnesses;
- Fifteen (15) of the articles focused on substance abuse/dependence self-help groups;
- Thirteen (13) of the articles focused on consumer run organizations (all except one overlapped with mental health);
- Eleven (12) of the articles focused on economic enhancement self-help groups; and,
- Six (6) articles focus on acute illnesses.

Out of the 102 articles, only fifty-nine (59) articles addressed one or more measures related to effectiveness of MASH strategies. Additionally, one (1) article was a systematic review focused on clinical effectiveness and seven (7) articles were general reviews of the MASH research studies.

The findings from the literature review are discussed below as follows: findings from the systematic review, general reviews and groupings of primary studies in the categories of mental health, physical illness, addictions, and economic/quality of life enhancement.

Systematic Review

Of the 102 articles retrieved, there was only one rigorously conducted systematic review by Woolacott et al (2006) published in the United Kingdom focusing on clinical effectiveness of self care support networks in health care and social care. The review included forty-six (46) studies through an extensive search of twelve (12) databases. The author's conclusions were as follows:

- The research studies comprised different types of self care groups.

- Peer led weight loss groups demonstrated that statistically significant but moderate weight loss can be achieved from such groups.
- Several beneficial effects were found for carers of people with schizophrenia, dementia and receivers of care in the areas of family functioning, family burden, carer distress, and quality of life.
- Self care groups for people with diabetes, depression, bulimia, arthritis/rheumatoid showed some beneficial outcomes related to coping and clinical outcomes.
- Weak evidence for benefits was found for self-help groups for people with cardiac recovery, psoriasis, and systemic lupus erythematosus.
- Lastly, there was no evidence of benefits from group participation for people with chronic pain, mental illness, epilepsy and injury.

Primary Studies

The following are studies that demonstrated benefits of MASH:

Mental Health:

MASH strategies have shown great impact on individuals with mental health challenges; particularly, as it related to use of health services and re-hospitalization. Edmundson et al (1982) reported that after ten months of participation in a patient-led, professionally supervised social network enhancement group, one-half as many former psychiatric inpatients required re-hospitalization as did non-participants. Participants in the patient-led network also had much shorter average hospital stays (7 days vs. 25 days). Furthermore, a higher percentage of members than non-members could function with no contact with the mental health system (53% vs. 23%).

Kennedy (1990) in a study found that 31 members of GROW, a self-help organization for people with chronic psychiatric problems, spent significantly fewer days in a psychiatric hospital over a 32-month period than did 31 former psychiatric patients of similar age, race, sex, marital status, number of previous hospitalizations and other factors. Members also increased their sense of security and self-esteem, decreased their existential anxiety, broadened their sense of spirituality, and increased their ability to accept problems without blaming self or others for them.

Burti et al (2005) compared self-help group members with non members from a community mental health centre. They found that self-help group members had decreased number of hospital admissions and days in hospital and were more satisfied with work/education than non members whose needs continued to be unmet. These and the above discussed findings point to significant resource savings for the health care system.

In a randomized controlled study of a self-help group for people with psychiatric problems, Galanter (1988) found that there was a decrease in the symptoms and other distresses for those who participated compared to before they joined the group. Those who participated longer in the groups also used less psychotropic medication and psychotherapy than those who had recently joined the group. Kurtz (1988) also found that

members of a self-help group of people with manic depression not only coped better after joining the group but their length of involvement was positively associated with how well they remained involved with the group. Similarly, Raiff (1984) found that members of a mental health self-help group who had participated two years or more had less worry and highest levels of satisfaction with their health. Those less than two years were on medication, lived below the poverty line or had less social connections. It appears that the length of involvement with a self-help group has benefits for participants of mental health groups.

A randomized study conducted by Chien et al (2005) involved assignment of family carers to three different groups: mutual support, psycho-educational and standard care groups. Measurements were taken at baseline, at six months and six months post twelve sessions of the facilitated mutual support group meetings. Differences between the mutual support and pscho-educational groups included the following: The mutual support groups were member led while the others were professional led; the mutual support groups were flexibility, involved patients in three of the twelve sessions and were encouraged to practice strategies at home; the mutual support groups also had significant positive outcomes on measures of family functioning and patient functioning but not on changes in use of external resources or readmission rates.

Another study on self-help groups targeting families of psychiatric patients found that participation helped reduce the sense of burden family members often carry (Potasznik & nelson, 1984). They also reported that they received information about schizophrenia and coping strategies which professionals didn't provide. In addition, the self-help group provided opportunity for social bonds to form with others who were experiencing similar problems.

Consume run organizations (CROs) have shown to have broad benefit to participants. Brown (2007) studied twenty (20) CROs and reported the following benefits of participation - empowerment, satisfaction, better coping, confidence, and decline in use of in-patient services. In a separate article, Brown (2007b) reports that sixty-eight percent (68%) of CROs had achieved the goals they had set as part of their accountability agreements.

Physical Illnesses:

Various self-help groups for people with different physical illnesses have shown benefits for its members. Decoster et al (2005) studied a diabetes self-help group, the Diabetes Club, which was a peer led, community-based self-help intervention. Positive outcomes in participants included improved self efficacy, self care behaviours and weight loss. Gilden et al (1992) found in a study of older men with diabetes that two years later, those who learnt self-care techniques and participated in member-run support groups were less depressed, less stressed, gained more knowledge, and rated the quality of their lives higher than those who didn't take such actions. Peer groups have also been identified to provide problem solving capability to young adolescents with diabetes to better manage their health (Anderson et al, 1989).

Simmons et al (1992) assessed members of a self-help group for South Asian diabetics in England for levels of glycated haemoglobin and knowledge about diabetes. Those who attended the group twice or more during a year had a significantly greater drop in glycated haemoglobin levels and a significantly greater increase in knowledge about diabetes. Although professionals helped start the group, it continued to operate independently, emphasizing education, mutual support, information sharing, and family social activities.

Fawzy et al (1993) found results that suggest that being part of a support group for persons at the early stages of skin cancer can increase their chance of survival threefold over a five-year period. Six months after the group sessions ended, two-thirds of the patients in the professionally assisted support groups showed an increase of 25 percent or more in what are called natural killer cells, cancer fighting cells in the immune system. No such increase was found in the control group.

Spiegel (1989) found that women in a professionally run breast cancer support group had a survival rate double that of the control group. The groups were led by professional facilitators who also had breast cancer.

Hinrichsen et al (1985) studied adults with scoliosis who had undergone bracing or surgery and participated in a Scoliosis Association self-help group. These adults were compared to adults with similar treatment who did not participate in the group. Compared to non- participants, self-help group participants reported (1) a more positive outlook on life, (2) greater satisfaction with the medical care they received, (3) reduced psychosomatic symptoms, (4) increased sense of mastery, (5) increased self-esteem, and (6) reduced feelings of shame and estrangement.

Addictions

Humphreys & Moos (2001) conducted a comparative study with a sample of patients in cognitive behavioral inpatient treatment programs versus 12 step oriented inpatient treatment programs. One year follow up results showed that the 12 step program which encouraged use of self-help groups did better than the inpatient treatment on all of the indicators: number of outpatient continuing care visits after discharge, amount of inpatient care, annual cost, rates of abstinence.

Humphreys et al (2004) review of the literature of self-help groups for drugs and alcohol dependent individuals provided the following conclusions:

- Most outcome effectiveness studies were conducted with Alcoholic Anonymous and with 12 step approaches as well as exclusively with adults.
- Very few studies focused on teens and substance abuse and little with non-12 step programs.
- Three randomized controlled trials of community based self-help programs showed poor outcomes.
- A couple of quasi-experimental studies found good results.

- The collaborative cocaine treatment study found those in self-help groups had more consecutive months abstinence from cocaine compared to professional treatment sample.
- Other studies cited positive results for groups for drug and alcohol dependents. Besides reduced use of drug/alcohol, other outcomes measured included increased self efficacy, reduced costs, depression, anxiety, improved social supports, coping with stress.
- Self-help groups good for continuing care rather than alone.

Humphreys and Moos (2001) conducted a quasi-experimental study to explain if encouragement of substance abuse patients to participate in self-help groups helped to reduce the demand for subsequent health care. They matched two groups of 887 male patients each on pre-study health care costs. One group was part of a 12 step program that encouraged the use of self-help groups and the second group was part of a cognitive behavioural treatment group. Baseline and one year data collection results showed that those in the 12 step program used significantly more self-help groups than the cognitive behavioural treatment group; the cognitive behavioural treatment participants had twice as much continuing care visits after discharge (22.5 visits) compared to 12 step program participants (13.1 visits); significantly more inpatient visits (17 days for the cognitive behavioral treatment; 10.5 days in 12 step program). The cognitive behavioural treatment group's annual cost was 64% higher than the cost for the 12 step programs. Additionally, the 12 step program participants had higher rates of abstinence at follow–up compared to patients in the cognitive behavioural treatment programs (45.7% versus 36.2%). Programs incorporating self-help groups have obvious advantage according to this study.

Laudet (2000) found that involvement in 12 step mutual aid group resulted in positive outcomes such as greater perceived support, successful recovery (decreased mental health symptoms and drug use) and higher levels of personal well being.

Masudomi (2004) conducted a longitudinal study evaluating five year mortality rate of alcohol dependent participants who participated in self-help groups. They found significantly better cumulative survival rate for those who participated in the self-help groups.

McKay et al (1994) reported significantly lower rates of substance abuse in a sample of 180 substance dependent, low income patients who participated in a self-help group. The strength of their study was in their data collection which included both self report and urine tests.

Parental participation in self-help group addressing their children's involvement with drugs and alcohol (Parent Resources Institute for Drug Education in the United States) has also resulted in positive outcomes. Parents reported that their children were better disciplined and adjusted outside the home as well as showed improvement in their drug problem (Galanter et al, 1984).

Members of a self-help group for narcotic anonymous remained off drugs three years or more, reported levels of anxiety and self esteem similar to group who had never had addictions. Length of involvement in the group was associated with better outcomes. The active involvement of group members in an AA groups have also been found to have better outcomes. A meta analysis of more than 50 studies had better abstinence from alcohol if they had a sponsor, participated in the health part of the program, lead a meeting or increased the degree of participation over time as well as sponsored other AA members (Emrick et al, 1993).

Economic and Quality of Life Enhancement

Cameron et al (2000) found significantly less out of home child placements in families where the parent(s) participated in a parent mutual aid organization (PMAO) group and less reliance on child support workers. Benefits reported also included mutual support, self-esteem, expanded social network for recreation, crisis, advice, etc. Potential for cost savings was noted as well as the quality of life of the family as a whole.

King (2000) studied nine support groups of parents of children with special needs. Parents attended support groups for social support, practical advice and a shared sense of purpose/advocacy which led to a sense of empowerment. Over time, the groups' main struggles for survival of the group were related to need for continual effective leadership, new members and funding support to assist with group activities and changing needs of members. Connecting with the community is one way of ensuring the recruitment of new members and for funding support. The need for existing members to be flexible in order to meet the needs of new members has also been found to contribute to longevity of a peer support group.

Hodges et al (2002) studied a group with severe disabilities who were homeless. 91% of the sample had a goal to work on at baseline prior to participation in self-help association. They found that 19% of participants achieved their goals at 6 months and 55% of participants were still motivated to work towards achieving their goals. Participant goals included housing, employment, training, mental health/health - all goals that take time and are challenged by constrained resources. Additionally, self-help group members' attitude towards professional mental services was positive, demonstrating the integrated use of self-help with traditional mental health care provision.

Vijayanthi (2002) studied women's self-help groups in five slum areas in Pulianthope, India involved in a non-governmental organization program to control diarrhea and other water born diseases. They reported the positive results with the following outcomes: group empowerment, personal empowerment, decision making and awareness creation.

Tarasuk (2001) reported on how groups of low to middle income members participated in various community kitchens in Canada with a view of receiving mutual support, skill development in the selection, purchasing and preparation of food and acquiring food to take home for later consumption. Although the food security goal of community kitchens

could be debated, there were benefits of mutual support reported by participants of this self-help activity.

In writing about community self-help and the homeless poor in Latin America, Stewart and Balchin (2002) state, "shack settlements are a quick and affordable housing solution created by, and for, the urban poor. Many policy-makers now regard community self-help among the homeless poor themselves as fundamental to policy solutions to the problem of housing need" (p. 103). Although many of these shack settlements are meager and do not have the necessary public service infrastructure of water, refuse, and other utilities, these self-help strategies have become the sustainable solutions where governments have not been able to address the need for housing. Some countries in Asia, Africa and Latin America are now partnering with self-help groups and developing "upgrade" schemes to enhance the living conditions in these shack settlements. The Slum/Shack Dwellers International is one example of communities working with their governments to secure available funding (Stewart, 2002).

Guthrie House, a community resource centre established in a small rural Canadian community is an example of how a small group of people recognized the need to have community and health services closer to their community. Using a self-help group strategy with a focus on building community capacity through fund raising, advocacy and engaging corporate, community and some government leadership, the group was able to establish and operate Guthrie House (Halseth, 1999). This community resource centre was a response to poor rural access to health and social support services. The response allowed the bringing together of various organizations under one roof, all paid by financial resources raised by the community.

Gaonkar (2003) studied self-help groups in India comprising of women that used money that they saved every month to contribute towards a common fund to help members meet their productive and emergent credit needs. The groups were provided loans through social economic enterprise programs while the women addressed non-credit supports to each other with respect to literacy, health and environmental issues. The groups of 10-20 members had a structure consisting of president, secretary and treasure while all members participated in decision making. These self-help groups were seen as capacity development opportunities for women on their path to improving their quality of life. Positive outcomes included increase in income, savings, and consumption expenditure as well as increase in self-confidence, stature in the family and society and a greater voice in both their personal and communal lives.

Social support is also a key outcome of self-help groups; especially, when people are dealing with stigmatized issues. Hill (2001) reported on a study of a self-help group for mothers of sexually abused children. The mothers found that talking about their feelings with others in a similar situation helped to address stigma, developed their personal skills in coping and an increased their ability to take action. Similarly, such support environments have been found to be helpful to self-help groups of single parents, divorced individuals, gays and lesbians (Ben Ari, 2002).

Another life event that creates a need for social support is during bereavement. A randomized study of women who were grieving after the death of their husbands was assigned either to a self-help group or to a psychotherapy group. Findings showed that the women in the two groups did not show any significant difference on stress specific symptoms or depression (Marmar, 1988). An earlier study by Vachon et al (1980) found bereaved women to have better adjustments from self-help group than those who were not part of the self-help intervention. The findings even after 12 months were positive in that the women were able to make new friends, had begun new activities and were less anxious. In both studies, self-help groups for bereaved women are a cost-benefit intervention.

General Reviews:

Seven published literature reviews were identified in this category:

1. Barlow et al (2000) conducted a meta-analysis of medical self-help groups using thirty-nine identified articles. The review compared medical self-help groups with wait list controls on pre admittance and post experience with self-help groups. Medical self-help groups comprised a range of topics such as physical illness, mental illness, substance dependence/abuse and grief/adjustment. The authors concluded that "self-help groups may, at best, produce small average improvements in patients" (p.65). Several methodological limitations were discussed in performing the meta-analysis including overlapping definitions of "medical" and "self-help", overlap between professional and non-professional led groups. There were differences noted in effect size of studies as follows: self-help groups dealing with substance dependence had greater benefits than groups with a physical or mental health focus; groups dealing with acute illness had greater benefits than chronic illness groups.
2. Boer et al (2004) conducted a meta analysis using fourteen (14) studies for biblio-therapy and self-help groups in the treatment of emotional disorders. They were unable to make any conclusions on the effectiveness of self-help groups due to the dearth of research studies.
3. Ferrie et al (2006) compared Alcoholic Anonymous and other 12 step programs for adults with other treatments for alcohol dependencies and found no significant differences. The authors noted several limitations in the studies used in the review.
4. Hogan et al (2002) conducted a review of the literature and compared three different types of studies: group versus individual social support interventions; professionally led versus peer provided intervention; interventions where an increase in network size or perceived support was the primary target versus those building social skills. 83% of studies (73) reported at least some benefits of support interventions relative to either no treatment or active controls.
5. Kyrouz et al (2002) conducted a review but did not synthesize the findings; rather provided a good listing of studies of effectiveness of self-help groups. Majority of the studies were from the 1980s and early 1990s.
6. Solomon and Draine (2000) reviewed and compared studies of effectiveness of various types of consumer run organizations: consumer operated consumer

partnerships and consumers as employees. They concluded that there was insufficient evidence to conclude effectiveness of consumer run organizations.

7. Solomon (2004) reviewed studies of peer support and peer provided services. They concluded that there are benefits of peer support albeit not strong evidence.

Limitations of Research Studies & Project

Although there are numerous research studies addressing MASH strategies and a great literary interest in this topic area, there are various limitations to be noted:

- The number and range of self-help groups out weighs the extent of research conducted. The proliferation of MASH has occurred independently of evidence that these strategies are effective. It is also not clear, which approaches are more effective than others since the implementation of MASH strategies tends to be adapted to suit local circumstances, resources and interests.
- It is not clear what key effectiveness measures are important and whether these are measured in a consistent manner.
- The studies conducted vary widely in the design and the rigour with which they are conducted. Many studies have small sample sizes and therefore difficult to identify whether there is an effect on the outcomes studied.
- Studies on self-help in relation to children and youth were virtually non-existant.

Discussion of Findings

The literature shows an encouraging support for MASH but not necessarily a definitive support for the effectiveness of MASH strategies in the areas of health promotion, capacity development, empowerment and community building. Some of the key arguments that could be used to support MASH include the emotional support that participants of self-help groups receive, the sharing of practical coping strategies and resources and providing a sense of confidence to participants to address their life circumstance. These positive benefits can be leveraged to support greater participation of individuals in their own care and communication with health care professionals.

A vast number of studies demonstrated the positive benefits of self-help groups in expanding the participants social support networks particularly when members continued their relationships outside of the group meetings. Videka-Sherman and Lieberman (1985) found that bereaved parents in self-help groups reported increased self confidence, sense of control, happiness and decreased depression, anxiety, guilt, anger and isolation. Women caring for frail older relatives who participated in a self-help group reported increase in their social network, knowledge of community resources, ability to deal with caregiving problems and better relationships with their loved ones (Toseland et al, 1989).

From a system perspective, and in particular with self-help groups of a health and wellness nature, there is an emerging evidence that self-help groups can decrease re-hospitalization, decrease length of stay in hospitals and thereby decreasing system costs. It is important to be clear that most of the literature is clear that MASH should be considered a complementary health/wellness strategy.

Although MASH is not purported as an alternative to traditional interventions in health or community social services, there are associated financial benefits that need to be noted. For example, through the use of Alcohol Anonymous self-help groups instead of hospital rehabilitation programs there has been documentation of cost efficiency by 10% to 45 % in various studies (Walsh et al, 1991; Humphreys and Moos, 1996). Additionally there are many studies that have demonstrated reduced costs associated with shorter hospitalization, less re-hospitalization, as well as less use of medications and other health care interventions (Edmunson and Bedell, 1982; Galanter, 1988; Kurtz, 1988).

Self-help groups with an aim of community development such as those of economic enhancement have shown greater promise; particularly, where these are linked to micro-credit or micro-finance schemes as seen in various developing country contexts. In fact, the United Nation's Millenium Declaration of 2000 adopted by 189 countries includes the use of self-help groups as a means of addressing poverty. Kumar (2007), however, does caution the singular use of self-help as she demonstrates through a study in India, that women of lower caste and class are particularly disadvantaged and use of self-help without addressing inequities (gender, income, education and general standards of living) in the local context does not change the health resources and improved health conditions of poor and marginalized people.

Similarly, there is moderate support for consumer run organizations in the developed countries such as United States and Canada as these relate to people with mental health conditions. The CROs not only provide on-going meaningful activity for those who are at high risk for being marginalized but who can be isolated and lonely. These types of self-help groups create opportunities for meaningful networking, sharing and caring for one another. The sense of "looking out for one another" has been discussed extensively albeit, not adequately captured in research findings.

The extensive number of self-help support groups and the informality of their existence could mean that many who could benefit from these groups may not necessarily know of them; particularly, as many such groups are not known to the existing self-help resource centres or clearinghouses. Experiences in other countries have indicated the valuable role that resource or advice centres can provide to known self-help groups including supporting their initial foundation, referrals of new members, consulting with groups on their ongoing operations and problem solving anticipated problems or challenges. Such centres can often provide space for meetings, links to experts as well as ad hoc supports to sustain the interest and value provided by the self-help membership.

Moving Forward

Self-help groups are often initiated, organized and operated by people experiencing a common concern; however, much more often, they require the support of professionals, organizations and public administration bodies. Several reports identified that over 60% of self-help groups had professionals supporting the groups in some manner (Barlow et al, 1999; Woolacott et al., 2006). It could be extrapolated that there is a need for an infrastructure of support to assist self-help groups without imposing on the essence of their purpose; that is, without unnecessary professional interference.

Various research studies show that supports are needed for raising awareness of the value of self-help groups (Anderson-Butcher, 2004; Stewart, 1990), marketing and referrals to existing self-help groups (Chinman, 2002; Salzer et al, 2001), educating professionals so they can see the value of self-help as a complementary strategy (Goldstrom et al, 2006), etc. Various studies have provided evidence that professionals are not referring clients to self-help groups because they either are not aware of the groups, feel that the groups will not be helpful, think that professionally led groups are better than client led groups or in the case of mental health, underestimate clients' ability to engage and participate constructively in such groups (Anderson-Butcher et al, 2004; Bui, 2002, Chinmon et al, 2002). Additionally, professionals need preparation/training in how to work in partnerships with self-help groups which are in contrast with the dominant expert paradigm (Stewart, 1990). There is a need to ensure the role of self-help resource centres continues in the areas of providing supports to address marketing, referrals as well as educating professionals and professional organizations with respect to the existence, value and ways of engaging the self-help groups as a potential continuum of support to the public. Providing formative education on MASH to students in various helping disciplines would also create a greater partnership and synergy in supporting people.

Self-help groups are constantly going through a turnover of members and without dedicated support to ensure there is recruitment of members, such groups can become extinct quickly leaving behind a void for those who require the supports. Consumer run organizations that have large membership are able to buffer against such threats as they are able to fill in leadership roles easily from their existing members (Brown, 2007). Processes to support self-help groups' renewal of members were found to be important for its sustainability. One could, however, argue that the natural termination of any self-help group should not be seen as a failure if the need for the group does not exist any longer. Nonetheless, avenues to provide support where needed is another role that self-help resource centres could help fill.

There are therefore, some clear recommendations that can be surmised from the above literature review:

1. Supports need to be expanded to self-help groups such as through existing or new self-help resource centres for a number of activities as stated earlier (awareness, marketing, referrals, training/education, etc).
2. There is a great need to better understand the range and quality of self-help/mutual aid groups in order to create better awareness of their existence as well as to provide the necessary support to these groups.
3. The dearth of research in understanding the effectiveness of MASH needs to be addressed in order to create both financial and strategic support for the promotion of MASH.

Research Areas:

There are a number of areas where additional research can help fill the gap in knowledge of MASH:

1. In Canada, there is a need to have better knowledge of the extent of involvement of its population in self-help and mutual aid groups in broad categories (e.g. special needs, mental health, elder care, chronic illnesses, etc). Such research would provide a better understanding of what types of self-help groups are needed, that is, where are the gaps. A survey similar to one conducted in Kansas by Wituk et al (2007) would allow a more comprehensive understanding of the current landscape of self-help groups in Canada.
2. Need to better understand the kinds of supports that are currently provided to self-help groups, what works and does not work in supporting self-help groups. This would inform self-help resource centres to develop better supportive practices.
3. Need to examine the role of professionals in supporting self-help groups. How does professional involvement help or not help? At what times is help needed? What type of training should professionals receive to support MASH activity?
4. There are a number of group operational functions that are unknown at present and require better insight: deciding on frequency of meetings; open versus closed membership; do passive members gain from self-help group membership comparedto active participants; size of groups for optimal benefit; fixed set of meetings or on-going, indefinite number of meetings; value of interaction outside of established meetings; training needs of group leaders (is this necessary, if so, what type of training, and for what type of groups would training be required); etc.

A number of research related issues surfaced in the literature review. Although there is greater political weight put on studies that are controlled and studied for effectiveness of intervention, there have been arguments put forth that self-help groups should not be controlled but compared to other existing or natural groups. It has been argued that controlling groups in research studies takes away from the essence of MASH which is self determination. Additionally, it is easier to study available self-help groups that are affiliated or connected with established institutions than those that function in more informal circumstances. Future research should seek out the latter groups for inclusion in research. There have also been suggestions put forth for more qualitative studies as well as participatory action research in order to create a balance of power between researcher and research subjects.

Conclusions

The literature review on MASH effectiveness has expanded the understanding on the range of studies that have been conducted. It is clear that there are extensive areas within the categories of physical health, mental health, addictions, economic enhancement and quality of life where self-help groups are being put to use. The research of effectiveness of MASH strategies continues to be challenged both in numbers of studies but more importantly in quality of methodology of the research. It is, however, important to note that there are increasing numbers of formal reviews conducted; albeit, only one rigourous systematic review. In order to better document the knowledge base of MASH strategies, it is recommended that there needs to be dedicated resources for research and for systematic reviews of existing research. Lastly, dissemination of such reviews is most important in order for the necessary uptake of promising practices.

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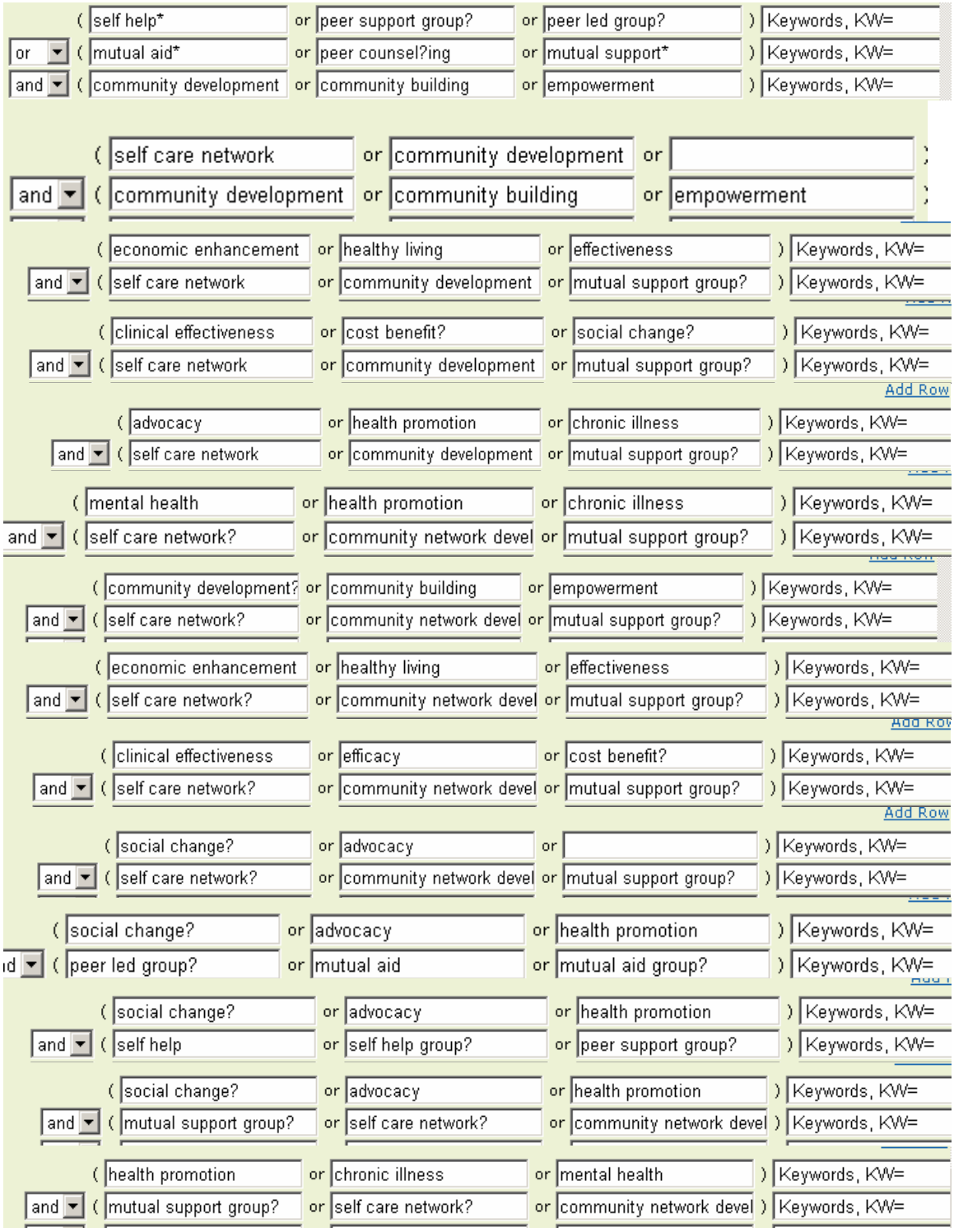
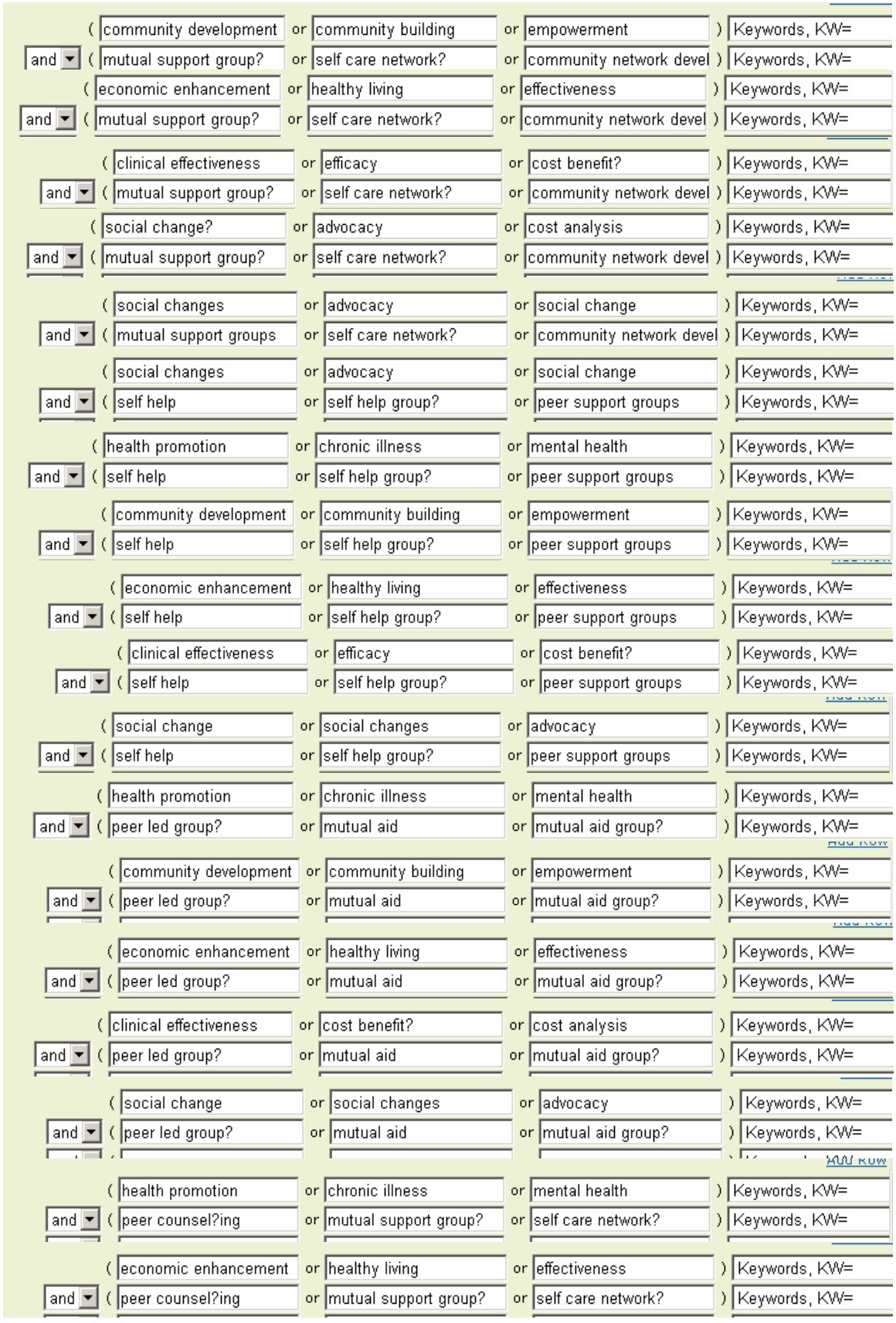
Appendix A

Search Strategy

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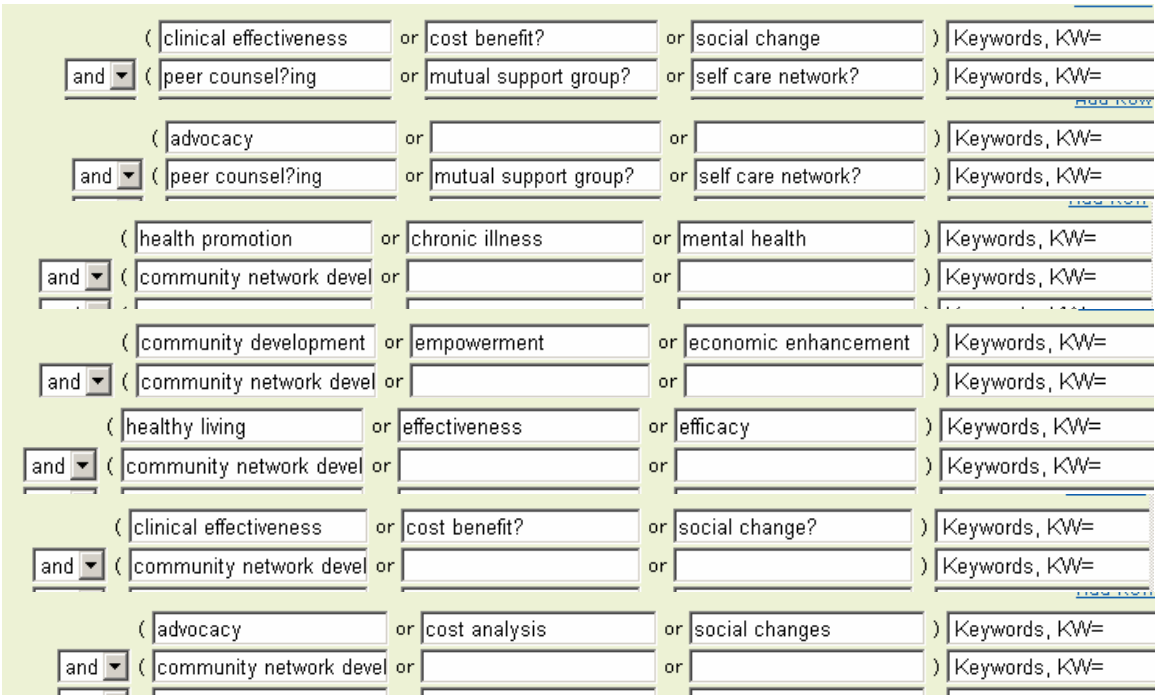
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