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Rediscovery of the Grassroots: Radical or Reactionary Trend?

by Terry Mizrahi, Ph.D.

Politicians, professionals and patients seem to have all re-discovered the virtues of so-called "self-help" and grassroots activities or what in the 1970's Alan Gartner and Frank Riessman identified as the "a-professional dimension of helping" and Harry Boyte labeled the "backyard revolution."This active formation of consumer and community groups has had multiple purposes over the years: providing support, raising consciousness, increasing resources, and changing policies; or in the language from Health Advocacy Course I, promoting "case/individual and cause/class advocacy." To this end, I applaud the many wonderful examples of groups described in this issue, many initiated by alumna of the Sarah Lawrence Health Advocacy Program and their colleagues. These are illustrations of innovative programs advanced by committed and competent professionals.

However, I would like to raise a few caveats, and caution leaders and participants as they advocate for and plan such activities. We are in an era of political and economic conservatism. This has led to a retreat in the government role in meeting human needs, a retrenchment of government-funded benefits and services, a take over of health and human services by the private, corporate sector, and even a redefinition and reframing of health care needs and services so that the public ultimately expects and demands less from their employer, their community and the state. It is also an era of downsizing and deprofessionalization while many public officials advocate for personal responsibility.

It is no wonder that the virtues of programs that call for self-help and that turn treatment over to consumer and family members are being extolled. However, these seemingly cheaper alternatives to professional care present several problems in the context of the conditions I described above. First, while more responsibility is being given to and expected by "natural helpers and supports", there are not the concomitant rights, redress and resources being provided to them. These methods must be based on appropriateness, accountability and effectiveness. For that to happen, resources and expertise must be provided. Without these, a "blame the victim" outcome could emerge as risk and responsibility is shifted to the patients and their helpers. While the Sarah Lawrence Health Advocacy Program philosophy has been a strong proponent of organized consumer/community involvement and influence, we have done so based on a social and ultimately, legal philosophy that promotes a "right to health care." This does not exist now.

Second, by accepting the term "self-help", people play into the hands of those who glorify individualism and competition. The term is a misnomer; it needs to be redefined as "mutual aid and support". The philosophy of the 12-step and related grassroots efforts recognizes that people can't and don't have to do "it" alone: indeed, that movement provides a community of belonging and acceptance, a group of people who can empathize with and support each other because they have all been there. Such groups foster interdependence and recognize the common experiences that bind people. It is the common and group definition of social problems that make these grassroots efforts so powerful. However, these programs are neither quick, nor easy, nor the only "fixes" for people. Hopefully, we will all continue to advocate for adequate regulation and resources to meet the needs of people, while we engage them in working on their own collective solutions to problems.

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