

KEY INGREDIENTS OF PEER PROGRAMS IDENTIFIED

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The Consumer Operated Services Program (COSP) Multi-site Research Initiative (1998-2007) found 46 common ingredients (CIs) of consumer-operated service programs and identified key peer practices that effectively promote psychological well-being, empowerment and hope of recovery among participating adults diagnosed with severe mental illness or impairment. The multi-site findings suggest that when consumer operated services programs are integrated within the continuum of community care they enhance opportunities for mental health consumers to live, work, learn, and participate fully in the community.

The COSP common ingredients are based on the Fidelity Assessment Common Ingredients Tool (FACIT) which was developed by mental health consumer providers as part of the COSP multi-site study. This Fact Sheet describes the 46 common ingredients of consumer-operated services and identifies the key peer practices that are the foundation of the COSP evidence-base.

THE PEER-TO-PEER APPROACH TO RECOVERY

COSPs are peer-run self-help organizations or groups that are administratively and financially controlled by mental health consumers. Most important, they provide persons with mental illnesses the experience of giving and receiving peer supports in empowering ways. Peer-to-peer supports encourage consumers to confront personal priorities and to rebuild their sense of self and purpose.

COSPs are not simply mental health services which are delivered by consumers. On the contrary, COSPs are independent, peer-run programs. They have a unique set of core beliefs, structures, and approaches to helping that are very different from traditional mental health services. For example, while traditional mental health services treat mental illness through biomedical approaches, COSPs promote mental wellness through peer-to-peer approaches based on the concept of self-help.

In general, they offer mutual support, community-building, services, and advocacy. COSPs provide participants with opportunities to “tell one’s story,” engage in formal and informal peer support, be mentored and become a mentor, learn self-management and problem solving strategies, practice skills for employment and everyday life, express oneself creatively, and to advocate for oneself or other peers.

COSPs were organized in the 1970s by mental health consumers in response to the degrading conditions they faced within the community in the wake of de-institutionalization. Over the past three decades, COSPs have matured, diversified and increased in numbers across the United States (Campbell, 2005).

The authors of a 2002 national survey estimated that there were 3,315 mutual support groups, 3,019 self-help organizations run by and for mental health consumers and/or family members, and 1,133 consumer-operated services in the United States (Goldstrom, Campbell, Rogers, Lambert, Blacklow, Henderson & Manderscheid, 2005). Mutual support groups reported that 41,363 people attended their last meetings; self-help organizations boasted a total of 1,005,400 members; while consumer-operated services had 534,551 participants in one year. A follow-up analysis of this data revealed that of the 7,467 mental health groups and organizations identified in the survey, there were approximately 2,100 mental health consumer organizations run by consumers for the purpose of providing services to other consumers (Goldstrom, Campbell, Rogers, Lambert, Blacklow & Henderson, 2004).

Today, there is a broad variety of COSP models, including:

- drop-in centers;
- mutual support groups;
- peer educator and advocacy programs;
- multi-service agencies with benefits counseling and case-management;
- specialized supportive services focusing on crisis respite, employment, housing; and,
- peer phone services (warmlines).

An emerging evidence-base of qualitative and quantitative studies and corroborative literature has produced a growing consensus among experts, policy-makers, administrators and consumers that COSPs meet scientific and stakeholder criteria for effectiveness.

- In *Mental Health: A Report of the Surgeon General* (1999) the benefits to mental health service recipients who participated in self-help, consumer-operated service programs, and traditional mental health services where consumers are employed as staff were finally recognized within the mental health community.
- In 2003, *The President's New Freedom Commission on Mental Health* acknowledged the emergence of the COSP evidence-base and further recommended that consumers and families be fully involved in orienting the mental health system towards recovery.
- From 1998 until 2007, SAMHSA funded the largest study of consumer-operated services programs in history. One thousand eight hundred and twenty-seven (1,827) adult mental health consumers participated in a randomized control trial of eight COSPs led by a research coordinating center at the Missouri Institute of Mental Health and a steering committee composed of site investigators, government project officers and consumers. The Consumer-Operated Services Program (COSP) Multisite Research Initiative found that when these programs were offered as an adjunct to traditional mental health services they significantly

empowered participants by promoting self-efficacy and esteem (Rogers, Teague, Lichtenstein, Campbell, Lyass, Chen, & Banks, 2007).

- As part of the federal effort to identify and implement evidence-based practices in real-life settings in order to transform mental health services into a recovery-based system of care, SAMHSA is currently developing the *Consumer-Operated Services Program Evidence-Based Practice KIT* for national distribution.

THE FIDELITY ASSESSMENT COMMON INGREDIENTS TOOL (FACIT)

From the beginning of the COSP multi-site study it was clear to researchers that even though a common measurement tool to assess outcomes of the participating COSPs had been developed, the diversity of the programs would make it difficult to analyze the combined results of the study.

The eight participating COSPs were different program models:

- Four programs were consumer-operated drop-in centers where consumers were offered a variety of services that varied depending on the center.
- Two programs were education and advocacy programs that used well-defined curricula to teach members about mental illness and advocacy in a classroom setting.
- Two programs were mutual support programs for individuals or groups organized around a worldview that was consistent with empowerment and recovery.

Also, if programs were sufficiently different within a model in how they implemented peer services, the true effects of COSPs would be masked. Therefore, it was critical to the success of the study to determine the degree to which all the COSPs operated according to a similar set of well-defined peer practices.

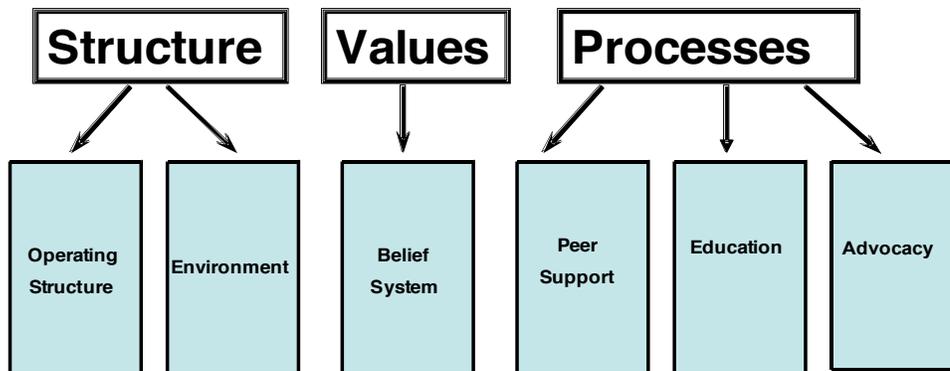
Under the leadership of the Consumer Advisory Panel (CAP), the multi-site study developed the Fidelity Assessment Common Ingredients Tool (FACIT) to measure program implementation. Building on previous literature (Campbell & Dumont, 1998; Mowbray & Holter, 2000) and their experience as consumers, the CAP defined 46 ingredients common to the eight participating COSPs. The common ingredients (CIs) were organized into the over-arching categories of Structure, Values and Processes and then sorted into domains within the categories based on similarity in peer practice content.

Structure reflected the “relatively stable characteristics of providers of care, of tools and resources they have at their disposal, and of the physical and organizational settings in which they work” (Donabedian, 1980, p. 81). It encompassed the domains of Program Structure and Program Environment.

Values related to the core set of principles, standards, morals and ethics that unite the program and its membership. Values were organized into the Belief System domain.

Processes referred to specific and observable activities in services or in methods of delivering those services. It was composed of the Peer Support, Education, and Advocacy domains.

CI Categories



1. OPERATING STRUCTURE

The COSP operating structure clearly distinguishes it from traditional mental health services. It is administratively and financially controlled by mental health consumers who plan, deliver, and evaluate their services. On the other hand, a traditional mental health provider offers services in community-based settings that are operated by mental health professionals.

Consumer-Operated

- **(CI 1)** Consumers constitute at least 51 percent of the board or group who decide policies and procedures.
- **(CI 2)** With limited exceptions, staff and volunteers consist of consumers who are hired by and operate the COSP.
- **(CI 3)** Consumers are responsible for making COSP hiring decisions.
- **(CI 4)** Consumers control the operating budget.
- **(CI 5)** Volunteer opportunities for COSP participants may include board and leadership positions, unpaid jobs, and paid staff positions.

Responsive to Participants

- (CI 6) The COSP is responsive to the needs and preferences of COSP participants. There are many opportunities for member input and the program displays a commitment to implementing recommended changes.
- (CI 7) Participants have formal ways to indicate dissatisfaction with their COSP and to have grievances addressed.

Linkage to Other Supports

- (CI 8) COSPs establish links to traditional mental health services.
- (CI 9) COSPs establish links to other COSPs.
- (CI 10) COSPs establish links to other service agencies within the community.

2. ENVIRONMENT

Environment captures the operational features of the program and includes both the physical and emotional space. The COSP environment fosters participant inclusiveness, and safety.

Accessibility

- (CI 11, CI 12) Consumers are able to get to the program by walking or taking public transportation, or the services come to the consumer.
- (CI 13) Hours of operation are geared to the needs of participants.
- (CI 14) COSPs are free to participants or charge a nominal fee.
- (CI 15) Efforts are made to insure that consumers with physical, sensory, or psychiatric disabilities can participate in COSP programming.

Safety

- (CI 16) The COSP provides a non-coercive, safe milieu. Fears due to past trauma are appreciated and assuaged, including trauma induced by the mental health system. There is no threat of commitment, clinical diagnosis, or unwanted treatment forced on participants except in cases where suicide or physical danger to other participants is imminent.
- (CI 17) Program rules to protect the safety of participants are developed by consumers for consumers—either by the participants themselves or by consumer staff—and agreed upon by all participants.

Informal Setting

- (CI 18) The physical environment of the COSP offers participants a comfortable setting with spaces arranged to create a sense of safety, belonging and support.
- (CI 19) Within the social environment there are no rigid distinctions between participants and staff such as “provider” and “client” do not exist. While some program components may be structured, there remains a sense of freedom and self-expression.

- **(CI 20)** The COSP creates a sense of fellowship in which people care about each other and together create a community.
- **(CI 21)** There is no pressure on consumers who attend the COSP to participate in COSP programming or any time limit to begin participation. Program schedules are flexible and adapted to individual needs.

3. BELIEF SYSTEMS

The COSP belief system is a core set of principles and values that unite the program in an evolving culture of hope of recovery, social connectedness, empowerment, and meaning in life.

Peer Principle

- **(CI 22)** Relationships are based on shared experiences and values and are characterized by reciprocity and mutuality. Staff and participants share their experiences of having psychiatric disabilities.

Helper's Principle

- **(CI 23)** The helper's principle recognizes that working for the recovery of others facilitates personal recovery. Help and advice are friendly rather than professional and do not demand compliance.

Empowerment

- **(CI 24)** Personal empowerment is encouraged and supported. The COSP helps participants develop a sense of personal strength through programming that builds personal strength and efficacy.
- **(CI 25)** Consumers are expected to be accountable for their actions and to act responsibly.
- **(CI 26)** Participants take active roles in the governance and decision-making processes within the COSP. There is significant participant recognition and feelings of membership to the group.
- **(CI 27)** Participation is completely voluntary. Participants choose the services or activities that best suit them. A choice between two or more services or activities should be available. However, the expression of choice also includes the right to choose none.

Recovery

- **(CI 28)** The COSP supports and encourages the hope of recovery as a positive process that is forward-focused, acknowledges individual strengths, and enhances participant well-being. Recovery is recognized as different for each individual and, therefore, is never rigidly defined or forced on participants.

Acceptance and Respect for Diversity

- **(CI 29)** Every person is afforded acceptance, respect and understanding based on his or her uniqueness and value as an individual or member of a diverse subgroup. There is broad acceptance of non-dangerous behaviors for which participants are not threatened with expulsion from the COSP. Behavior is regarded in common human terms rather than interpreted through clinical labels. There are accommodations available for diverse subgroups.

Spiritual Growth

- **(CI 30)** Spiritual beliefs, practices, and transcendent experiences are respected as an aspect of an individual's search for meaning and purpose in life. Spiritual beliefs are not labeled as symptoms of mental illness. However, a COSP may have restrictions about proselytizing for a particular religion during the hours of operation.

4. PEER SUPPORT

Peer support refers to the concept of consumers helping and empowering each other. The peer-to-peer relationship implies reciprocity, equality, and mutual acceptance and respect. Peer support takes many forms. It can be as simple as two people getting together over a cup of coffee, or it can involve a formal group structure with facilitating rules that guide group discussion, education, advocacy, or creative expression.

Peer Support

- **(CI 31)** Formal peer support is offered within organized mutual support groups and is based on common experiences. Peers are available to each other for empathy and to share experiences and information. Formal support groups may supplement informal peer support.
- **(CI 32)** Informal peer support is mutual support based on common experiences that occurs in unscheduled group interactions and within individual relationships. Individual program participants are available to each other to listen with empathy and compassion.

Telling Our Stories

- **(CI 33)** Sharing personal accounts of life experiences as a mental health consumer is a cornerstone of promoting peer- well-being and recovery. Opportunities to tell one's story and open discussion about such stories are embedded in peer support groups, in peer-to-peer interactions, at public forums, and within boards and committees. Sharing life experiences may also be a tool for public education.

Artistic Expression

- **(CI 34)** Artistic expression is seen as a vital component of a COSP. It is valued as a means to explore personal meaning, express and grow talents, facilitate empowerment, and educate others about mental illness. COSP members have the

time, space, materials, and assistance to express themselves through artistic endeavors.

Consciousness-Raising

- **(CI 35)** COSPs provide opportunities for consumers to learn about the consumer movement. Participants are encouraged to look beyond themselves, to work together, to help fellow peers, and to contribute to a larger consumer community. New participants discover commonality with others, leading to hope and empowerment.

Crisis Prevention

- **(CI 36)** Formal crisis prevention occurs when members and staff learn to recognize psychiatric problems and how to address them before they escalate. Through individual or group peer support, by peer counselors, or by education and advocacy, COSPs can minimize involuntary commitments.
- **(CI 37)** Informal crisis prevention occurs when spontaneous mutual support occurs that averts a psychiatric crisis outside of any formal peer support framework.

Peer Mentoring and Teaching

- **(CI 38)** Consumer staff and leaders serve as positive role models to other consumers and to each other. Individual participants act as mentors to others. Consumers teach skills and strategies to other consumers, either formally or informally.

5. EDUCATION

Many COSPs focus on education of their members and the larger community. Although topics for educational activities should be determined by group interests, certain topics are so inherently important to COSPs that they are reflected in the common ingredients. Among these core topics are recovery and wellness, employment, and mental health planning and policy-making.

Formally Structured Self-Management and Problem-Solving Strategies

- **(CI 39)** COSPs teach and model practical skills and promote strategies related to personal issues, symptom-management, and helping to resolve support needs. The focus is on practical solutions to human concerns. Formally structured problem-solving activities are offered on a regular basis with skill development objectives. Members teach and learn skills that will equip them to participate fully in the community, such as daily-living skills, vocational skills, job readiness, communication skills, goal setting, and assertiveness skills.

Receiving Informal Problem-Solving Support

- (CI 40) The COSP provides a natural social environment where consumers develop and improve social skills. There is an unstructured, peer-to-peer exchange of personal, lived experiences that can enhance an individual's problem-solving abilities.

Providing Informal Problem-Solving Support

- (CI 41) Peers help each other to solve problems on an ad hoc basis using skills that they have acquired through the COSP or through lived experience.

Formal Skills Practice

- (CI 42) Peers teach and are taught skills within a formal group setting that will equip them for full participation in the community such as daily living skills, vocational skills, job readiness, communication skills, relationship-building, goal setting, anger management, and assertiveness skills.

Job Readiness Activities

- (CI 43) The COSP provides opportunities to acquire skills that are directly relevant to working such as resume writing or are indirectly relevant such as public speaking.

ADVOCACY

Self advocacy, peer advocacy, and system advocacy are embraced within the pressure-free environment of the COSP. Peers support each other in learning how to find one's own voice, to speak on behalf of another, or to support the common cause of members or consumers in general by testifying before a legislative committee or serving on a board or committee. COSPs engage in public education initiatives to bring about positive changes in attitudes about persons with mental illness.

Formal Self-Advocacy Activities

- (CI 44) COSP members learn to identify their own needs and to advocate for themselves when there are gaps in traditional mental health services. Peers learn to become active partners of professional mental health providers in developing their own service plans and how to deal effectively with entitlement and other service agencies.

Peer Advocacy

- (CI 45) Peers assist each other in resolving problems they may encounter in hospitals and in the community with treatment providers, community service agencies, family members, neighbors, landlords, and peers.

□ **Participant Outreach**

- **(CI 46)** The COSP makes concerted efforts to keep members informed of current activities and opportunities outside of the COSP.

FACIT Results

The COSP multi-site study found the FACIT to be an objective, structured way to determine the extent that a peer-run services program faithfully implemented the COSP model, processes, and values (Johnsen, Teague & McDonel Herr, 2005). It identified characteristic differences between COSPs and traditional mental health programs and differences between COSP program models, and helped to establish evidence of a strong relationship between an increase in well-being and recovery-oriented program features. In particular, CIs that support inclusion and self-expression were found key to promoting hope, empowerment, meaning in life, and self-efficacy among participants.

KEY INGREDIENTS

Environment Domain (Inclusion CIs)

- Services free of charge
- Program rules ensure physical safety, developed by consumers
- No hierarchy, sense of freedom and self-expression, warmth among participants and staff
- Sense of community, fellowship, mutual caring, and belonging
- Lack of coerciveness, no threats or unwanted treatment, tolerance of harmless behavior, emphasis on participant choice

Peer Support Domain (Self-Expression CIs)

- Opportunities for telling one's story in visual arts, music, poetry
- Opportunities for sharing life experiences
- Structured groups for listening, empathy, and compassion based on common experience

When results of the FACIT are analyzed, researchers are able to pinpoint program weaknesses, clarify program strengths, and associate various program outcomes to key CIs. Such capabilities advance the capacity of researchers, peer providers, and mental health administrators to promote evidence-based practices in developing consumer-operated services, to guide quality improvements in mature COSPs, and to identify and measure “consumer-friendly elements” of traditional mental health programs.

PUTTING KEY INGREDIENTS INTO PRACTICE

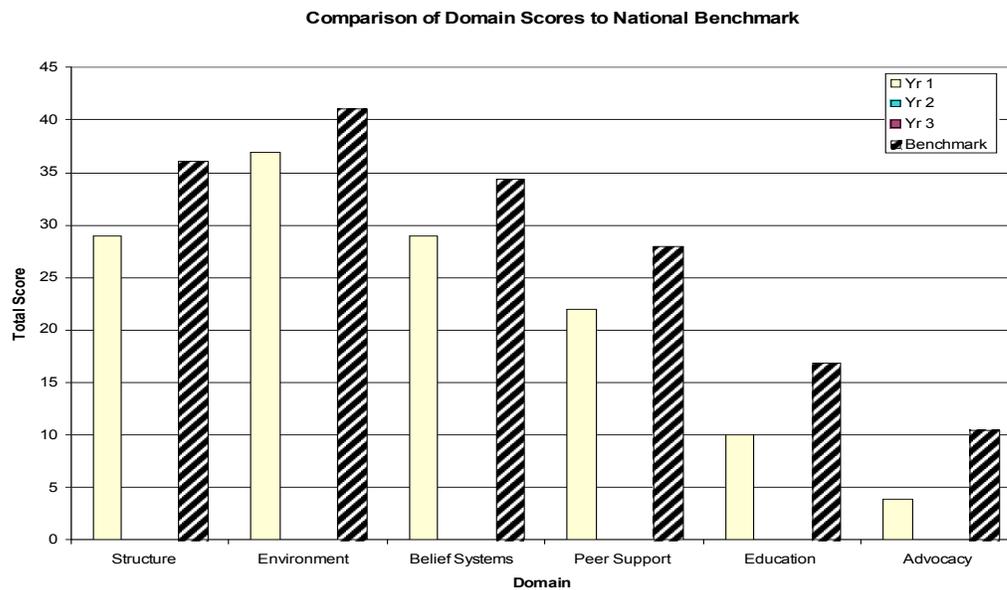
As states adopt an evidence-based practice approach to the delivery of mental health services, there are growing demands for consumer-operated services to examine the fidelity and effectiveness of the peer services they provide. It is doubtful peer programs can continue to expand beyond current operations if they lack valid, reliable tools to evaluate program effectiveness and improve the quality of their workforce. This call for accountability has challenged peer-providers to finance and build a data support infrastructure with quality improvement processes and trained personnel that support peer values and the lived experience of program participants.

The FACIT protocol is now available to the field in order to measure the common ingredients of peer practice. It can be used at the discretion of individual programs through a quality improvement team approach or as part of an external monitoring system. Implementation is based on program choice, and is intended to build skills and be empowering. Whether a program is a new, developing or a mature peer service, it could benefit from fidelity measurement of the CIs to

- pinpoint strengths and weaknesses,
- formulate action plans to improve peer practices,
- help participants achieve their goals, and
- deliver peer services both efficiently and effectively.

The *e-FACIT Workbook and Users' Guide* developed by Jean Campbell, PhD, and Rita Adkins, MPA, at the Program in Consumer Studies & Training at the Missouri Institute of Mental Health (MIMH) is also available to be used as a companion piece to the FACIT protocol. Designed to be user-friendly, the *e-FACIT Workbook and Users' Guide* provides (1) a brief overview of the development of the FACIT, (2) the e-FACIT computer program (Excel 2003 Workbook), and (3) a users' guide to the features of the e-FACIT computer program.

The **e-FACIT Workbook** enables COSPs to enter their FACIT scores from the anchored scales found in the FACIT Score Sheet, to password protect FACIT data, to automatically chart the scores for the five common ingredients domains and each of the 46 common ingredient items in bar-graph format, and to copy and print FACIT results and charts. The charting feature of the e-FACIT Workbook also allows a COSP to compare its program fidelity scores with national benchmarks developed from the aggregated scores of the eight COSPs that participated in the COSP Multisite Research Initiative and/or with previous FACIT scores of the individual COSP.



For More Information

For technical assistance or to obtain a free demonstration copy of the *e-FACIT Workbook and Users' Guide* contact jean.campbell@mimh.edu; www.cstprogram.org

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