Consumer Operated Service Providers and Local Mental Health Authorities:

Assessment of Current Models, Training, and Technical Assistance Needs

CENTER FOR SOCIAL WORK RESEARCH

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This report presents findings of an assessment of Consumer Operated Service Providers (COSPs) and their associated Local Mental Health Authorities (LMHAs) conducted for the Department of State Health Services (DSHS) by research staff at the University of Texas at Austin, Center for Social Work Research (UT-CSWR). The report is organized into four sections and includes an appendix.

Section I. provides an introduction, aims, and methods of the assessment.

Section II. presents an overview of the aggregated findings, providing an overall view of DSHS funded COSPs across the state of Texas.[1]

Section III. provides conclusions and a summary of findings, including comments on training and technical assistance related to COSP sustainability and expansion.

The Appendix includes copies of the introductory page of the online survey.

[1] *NOTE: There may be more than seven COSPs in the state of Texas. However, for this assessment, only the COSPs and LMHAs that contract with them using specific COSP funding from DSHS will be discussed.*

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I. Introduction

The Consumer/Survivor Movement

Historically, individuals with a mental health diagnosis were placed in state psychiatric hospitals with little hope that they would ever return to the community to live meaningful, productive lives (Swarbrick, 2009). These individuals were often forcefully institutionalized for an indefinite amount of time and subjected to harsh treatments such as shock therapy and lobotomy, which often harmed the patients that they intended to help. Fortunately, two former psychiatric patients and early advocates, Elizabeth Packard and Clifford Beers, began to speak out about their experiences in mental health institutions. In 1868, Packard published a series of pamphlets describing her experiences in an insane asylum to which she was forcefully committed by her husband and later founded the Anti-Insane Asylum Society (Chamberlain, 1990). Similarly, Beers was committed to a state hospital by his family after suffering psychotic episodes. He depicted his brutal treatment during his 3 year stay at the psychiatric institution in an autobiography entitled *A Mind That Found Itself* in 1908. Beers went on to found the National Committee for Mental Hygiene (Chamberlain, 1990) and the National Mental Health Association, which is currently known as Mental Health America, in 1909 (Frese & Davis, 1997; Swarbrick, 2009).

These early reformers as well as the civil rights movement of the 1950's and 1960's paved the way for the beginning of the consumer/survivor movement in the early 1970's. Like early activists Packard and Beers, former patients began to rally together to protect basic human rights of mental health consumers in institutional settings (Frese & Davis, 1997). Gradually, ex-patient/survivor groups emerged, such as the Insane Liberation Front in Oregon and the Mental Patients' Liberation Project in New York. Grounded in ideals of autonomy and informed consent, they began advocating for the empowerment of mental health consumers as well as the freedom of choices regarding treatment (Chamberlain, 1990; Frese & Davis, Swarbrick, 2009). These groups disputed involuntary and oppressive institutional mental health treatment and, instead, encouraged community-based treatment, support, and resources (Goldstrom, et al., 2005). In 1976, the President's Commission on Mental Health was established, which further advocated for the rights of mental health consumers. Since then, national consumer organization groups such as the National Depressive and Manic-Depressive Association and the National Alliance on Mental Illness (NAMI) have emerged in addition to the Center for Mental Health Services of the federal government. The establishment of these groups and organizations represents a push toward a mental health system in which consumers are recognized as active participants in and as instrumental components of treatment, support, and recovery.

A Consumer Driven Mental Health System

The President's New Freedom Commission on Mental Health (2003) was charged with determining the unmet needs and barriers to care for individuals with severe mental illnesses as

well as making recommendations to improve the current service delivery system. As a result, the Commission proposed a transformed mental health system that is, among other things, consumer and family driven.[2] The ultimate goal of the transformed mental health system is to promote recovery. Therefore, treatment and supports within one's community should be tailored to the needs of the individual (i.e., patient-centered). The individualized plan of care should offer an array of coordinated treatment options; include consumers and the family members of consumers in the planning of services, treatments, and support; and, facilitate access to available community resources. Consumer operated service providers (COSPs) represent a promising service delivery mode that may help the current public mental health system achieve these goals (2003).

Consumer Operated Service Providers

COSPs are "independent, non-profit organizations, funded largely by state and local mental health authorities to provide peer support and other non-clinical services to consumers in the public mental health system" (Tanenbaum, 2010) and rely heavily on the notions of social support (Segal, Hodges, & Hardiman, 2002), experiential knowledge (Gidron & Hasenfeld, 1994; Hasenfeld & Gidron, 1993; Hodges & Hardiman, 2006), and consumer empowerment (Nelson, Ochocka, Janzen, & Trainor, 2006; Schutt & Rogers, 2009; Swarbrick, Schmidt, & Pratt, 2009). These organizations are founded, governed, and run by mental health consumers, with some degree of non-consumer involvement in many cases (Holter, Mowbray, Bellamy, MacFarlane, & Dukarski, 2004; Jacobson & Curtis, 2000; Wituk, Vu, Brown, & Meissen, 2008). While traditional mental health professionals typically rely on personal education and expertise to provide clinical services, such as medication management and counseling, consumer providers tend to focus on the social, emotional, and vocational needs of mental health consumers (Swarbrick, 2009). Consumer provided services are delivered in a safe, supportive, non-judgmental environment that facilitates open discussion and problem-solving (Holter et al., 2004). These COSPs, and similar organizations, are gaining momentum in the public mental health system. In fact, Goldstrom and colleagues (2005) estimated the number of existing mental health mutual support groups, self-help organizations, and consumer-operated services nationwide in 2002 to be approximately 7,467, which greatly outnumbers the estimated 4,546 traditional mental health organizations.

Although in its infancy, research has shown a positive effect of consumer provided services on individual outcomes. COSP staff members have lived experience with mental illness and are often able to relate to consumers on a deep level, thereby increasing consumer engagement with

[2] For the purposes of this report, the term consumer refers to an individual who is currently receiving or has received services for a mental health diagnosis. A family member refers to a one of the following relationships with a consumer: spouse or domestic partner; biological child, parent, grandparent, grandchild, sister, or brother; or a spouse's or domestic partner's child, parent, or grandparent.

mental health services (Schutt & Rogers, 2009) and broadening their social support network (Brown, Shepherd, Merkle, Wituk, & Meissen, 2008) while at the same time reinforcing their own recovery process. Furthermore, individuals who are employed at COSPs are generally further along in their recovery than others (Chinman, Young, Hassell, & Davidson, 2006) and are contributing to society and the community in meaningful ways by working, be it in a paid or volunteer capacity (Segal, et al., 2002). Thus, they frequently serve as role models (Hodges & Hardiman, 2006; Segal et al., 2002), providing mental health consumers with a sense of hope that recovery is possible. Because COSPs and community mental health centers (CMHCs) serve similar populations, are working towards shared goals (Hodges & Hardiman, 2006), and are located within close proximity to one another (Segal, Hodges, & Hardiman, 2002), they are often regarded as being in competition (Hodges & Hardiman, 2006). However, research has shown that when these two types of organizations work collaboratively their services are actually complementary and their effects cumulative, resulting in more positive outcomes for mental health consumers (Gidron & Hasenfeld, 1994; Hasenfeld & Gidron, 1993; Hodges & Hardiman, 2006). The information gathered from COSPs and LMHAs in this assessment supports these findings.

Collaboration between Mental Health Agencies and COSPs

In the current mental health system, a strong emphasis has been placed on the provision of recovery-oriented services, resulting in the recognition of consumer-provided services as an essential part of mental health treatment (Jacobson & Curtis, 2000). Increasingly, professional mental health agencies are delegated the task of providing clinical services, while consumer provider agencies are charged with providing more social services (Segal et al., 2002). To provide mental health consumers with the most comprehensive array of services, these two organizations should necessarily work collaboratively and interdependently with one another (Hodges & Hardiman, 2006). Organizational collaboration is a mutually beneficial relationship between two agencies (Hodges & Hardiman, 2006). When utilized appropriately, both organizations may benefit from gains in effectiveness, efficiency, resources, capacity, legitimacy, and social development (Lawson, 2004). Interdependence refers to the degree of reciprocity in the relationship between two organizations. In terms of the relationship between mental health authorities and COSPs, the mental health authorities may benefit from the COSP staff members' experiential knowledge of mental illness and treatment while the COSP benefits from the mental health authorities' professional expertise and technical assistance (Hodges & Hardiman, 2006). Thus, mental health authorities and COSPs should strive to develop reciprocal, mutually beneficial relationships with one another. Hasenfeld and Gidron (1993) developed a framework that presents varying degrees of collaboration that can occur between two organizations. According to this framework, the collaboration between consumer-run and

community mental health agencies can be categorized into one of four hierarchical stages of interaction: 1) referral, 2) coordination, 3) coalition, and 4) cooptation/joint ventures.[3]

To the researchers' knowledge, only one study (Campbell, 2004) to date has examined the impact of receiving services from both the mental health authority and COSPs on individual consumers. Campbell (2004) randomly assigned participants to consumer-operated programs and traditional mental health services or only traditional mental health services in order to determine the effectiveness of the consumer-operated programs. Participants' overall well-being was assessed at baseline, four, eight, and twelve months after the intervention. Well-being was operationalized through the constructs of recovery, social inclusion, empowerment, quality of life, meaning of life, and hope. Findings indicate that those who received services from both organization types experienced greater improvements in overall well-being compared to those who received services from the traditional mental health services only. Although additional empirical research needs to be conducted, these findings seem to suggest that collaborative efforts between these two types of organizations greatly benefit individual consumer outcomes.

Aims of the Assessment

In Texas, seven COSPs are funded by the Department of State Health Services (DSHS) through a subcontract with the seven local mental health authorities (LMHAs) located in geographical proximity to them. In order to gain an understanding of the COSP-LMHA models (see Table 1), determine how COSPs could be expanded throughout the state, and identify training and technical assistance needs that would assist COSPs in developing the organizational capacity to become more self-sustaining, DSHS contracted with the University of Texas at Austin's Center for Social Work Research (UT-CSWR) to conduct an assessment of the COSPs and their associated LMHAs[4]. The data collected by UT-CSWR will be provided to DSHS and Via Hope, Texas Mental Health Resource, who was contracted by DSHS to provide training and technical assistance to the COSPs based on the needs identified in the assessment.

[3] This framework and a presentation of the individual COSP-LMHA models are discussed in the full report.
[4] This assessment was reviewed and approved by the University of Texas at Austin and the Department of State Health Services Institutional Review Boards.

Table 1. List of Corresponding COSP and LMHA Sites Included in the Assessment

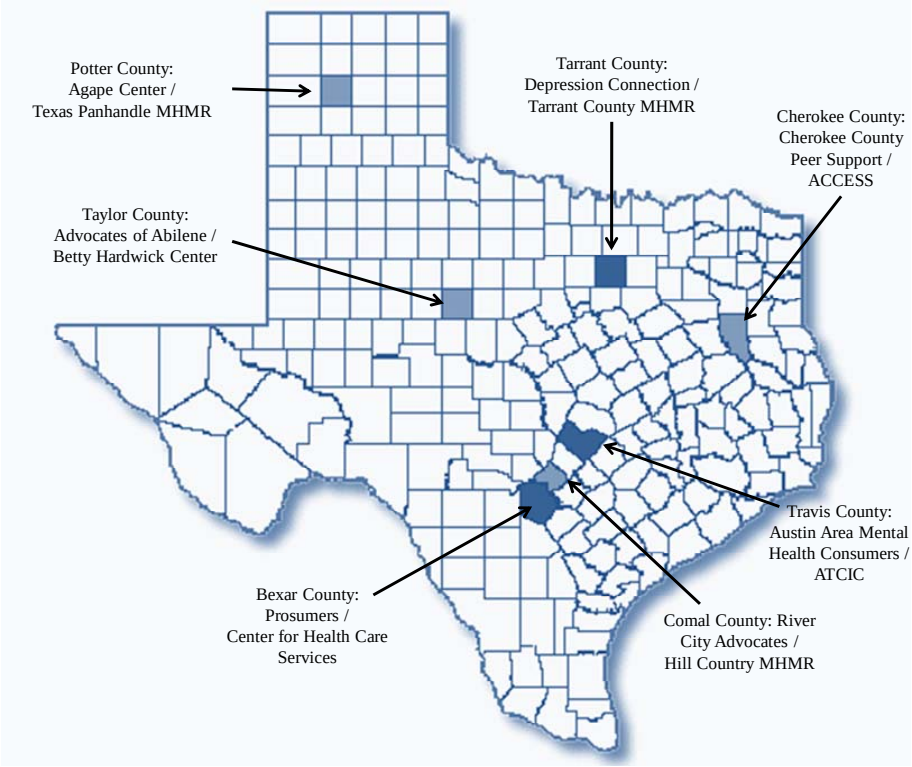
Consumer Operated Service Provider	Associated Local Mental Health Authority
Advocates of Abilene, Inc.	*Betty Hardwick Center*
Agape Center	*Texas Panhandle MHMR*
Austin Area Mental Health Consumers	*Austin Travis County Integral Care*
Cherokee County Peer Support Group	*Anderson/Cherokee Community Enrichment Services*
Depression Connection	*MHMR of Tarrant County*
Prosumers International	*The Center for Healthcare Services*
River City Advocacy, Inc.	*Hill Country Community MHMR*

Methods

Participants

Respondents were the Executive Directors or Associate Executive Directors of the COSPs and a contact person at the LMHAs, designated by DSHS. The job titles of the contact persons from the LMHAs were Director of Programs, Chief Executive Officer (*n*=2), Director of Contract Management/Provider Relations, Director of Mental Health Services (*n*=2), and Project Manager. In some cases, the contact person invited other individuals who communicate with the COSP frequently (i.e., Peer Support Coordinator, Case Manager Trainer, etc.) to help complete the survey and/or interview. The organizations are located across the state of Texas (e.g., Abilene, Austin, Amarillo, Fort Worth, Jacksonville, Kerrville, New Braunfels, and San Antonio) in urban, suburban, and rural areas. The map below (Figure 1) shows the locations of the affiliated COSPs and LMHAs throughout the state.

Figure 1. Map of COSP and LMHA Locations



Data Collection

Data was collected using a two-pronged approach. An online structured survey was first used to collect broad, general information and then also to inform more tailored, probing questions used during a follow-up, semi-structured phone interview. The researchers at UT-CSWR felt this mixed methods approach would provide a more complete understanding of the current models as well as their needs for sustainability and expansion. The survey was developed with input from Via Hope staff, the MHT Project Director and DSHS staff, past surveys conducted by the Mental Health and Substance Abuse Division, and a review of the literature (McBride, et al., 2009; Wituk, et al., 2008; Hodges & Hardiman, 2006; Van Tosh & del Vecchio, 2000; Potter & Mulkern, no date) and organized into the following 9 areas of interest:

1. Goal or Mission of the Organization and/or Reason for Providing Services via COSPs
2. Operations
3. Staffing
4. Funding
5. Communication
6. Outcomes and Impact of COSPs in the Community
7. Immediate and Ongoing Training and Technical Assistance Needs
8. Sustainability
9. Recommendations for Sustainability and Expansion

The surveys were administered through Survey Monkey, a secure, online survey administration tool. Respondents were sent an email describing the purpose of the evaluation, which included a link to the survey. A unique link was created for each organization. Upon following the survey link, participants were directed to an introductory page describing the intent of the evaluation, the methods used to collect data (e.g., survey and interview), the ways in which their responses would be shared with a broader audience, the structure of the survey, as well as contact information for the researchers. A copy of this introductory page is included in Appendix A. At the bottom of this page, there was a “Next” button, which the respondents were instructed to press in order to continue on to the survey. Participants were given a full calendar month to complete the survey and were able to return to the survey at any time during this administration period to modify and/or change their responses.

After completion of the surveys, individual responses were compiled into a summary report and sent back to the participants for verification purposes. Researchers then scheduled an interview with each organization over a two-week time period to ask additional follow-up and clarification questions. For the LMHAs, interviews were typically 30 minutes to one hour in duration. COSP interviews generally lasted longer, between one and a half hours and two and a half hours. The reason for this time difference is related to the aims of the assessment. DSHS requested information identifying COSP TTA needs as well as how the COSPs can be expanded

throughout the state; therefore, there were more follow up questions for the COSPs compared to the LMHAs. Responses from the survey and interview were once again compiled into summary reports and sent back to the participants for verification.

Overall findings from the assessment are presented in the following section and organized by the 9 areas of interest listed above.

II. Overview of Findings

Mission of the Organizations and/or Reason for Providing Services via COSPs

Mission Statement

In the current assessment, the 14 participating organizations were asked to provide their mission statement in the survey portion of the assessment (Table 2). The LMHA mission statements tend to highlight the provision of services/programs and enhancing the lives of individuals with mental illnesses whereas the COSP mission statements emphasized themes of recovery, empowerment, advocacy, education, and community. As mentioned previously, although these two organizations are targeting the same population and are working towards similar goals (Hodges & Hardiman, 2006), they are utilizing different methods to achieve these goals and these distinct methods are reflected in their mission statements. More specifically, staff members at LMHAs generally rely on their education and professional expertise in the mental health domain and provide services such as medication management and counseling (Segal, Hodges, & Hardiman, 2002). On the other hand, COSPs tend to focus less on the diagnosis and more on social/peer support and integration into the community through the facilitation of peer support groups, recreation/socialization activities, teaching self-advocacy and accessing available resources.

Table 2. Missions of COSPs and LMHAs

COSP MISSION	LMHA MISSION
"Empowerment and self-determination, promoting recovery/basic human needs, consumer-controlled, education emphasis, peer support, advocacy/protection of rights, inclusiveness and diversity, collaboration, and confidentiality."	*"To work hand in hand with those around us to assure a choice of effective, efficient programs and caregivers, and to offer excellent services that enhance quality of life."*
*"To empower and promote self-esteem; Act as a resource for information and services; Partner with community organizations through S.H.A.R.E. (Support, Hope, Advocacy, Responsibility, Education)" *currently under revision**	*"To improve the lives of people affected by behavioral health and developmental and/or intellectual challenges."*
"To provide training and education to consumers of mental health services to equip and empower them to experience recovery, to provide and receive positive support and to be informed self advocates."	*"To assure the delivery of a network of services to our customers that optimizes individual potential for wellness, independence, dignity and responsibility."*
"To empower people to live their lives fully and recognize that their life experience makes them stronger."	*"To improve the lives of people with mental health, developmental disabilities, and substance abuse challenges."*
"To foster our consumers' recovery and well-being through educational and innovative programs developed to strengthen and improve the coping skills, self-confidence and independence necessary for successful integration into the community."	*"Promoting Independence, Community Integration, and Recovery."*
"To help relieve the pain and improve the health of people who are suffering as a consequence of mental illness."	*"To enhance the mental health and intellectual development of people in our community."*
"To organize, encourage, educate, and train mental health consumers to advocate for themselves and support each other in their recovery. The group's vision is the integration of individuals diagnosed with mental illness into the community as productive, functional, valued citizens."	*"To respond to the diverse needs of people with mental illness and mental retardation by creating an accessible system of services which supports individual choices and results in lives of dignity and independence."*

Type of Organization

The COSPs were asked to select from a list of terms the one(s) that best described their organization during the survey portion of the assessment and were asked to explain why they selected each term during the interview process. The extensive list of terms were gathered from a review of the literature on consumer operated services and included: self-help agency, consumer-run drop-in center, consumer/survivor organization, consumer operated center, consumer operated service provider, drop-in center, club house, day support program, education program, advocacy program, independent peer support program, therapeutic recreation/socialization program, and other. All COSPs (*n*=7) responded to this question and their answers are summarized in Table 3 below. The terms selected most frequently (*n*=5) were "self-help agency," "consumer operated service provider," and "independent peer support program." Organization types selected least frequently (*n*=1) were "drop-in center," and "day support program."

Table 3. Type of Organization

Organization Type	Number of COSPs selecting Organization Type
Self-help agency	***5***
Consumer operated service provider	***5***
Independent peer support program	***5***
Consumer operated center	*4*
Education program	*4*
Consumer/survivor organization	*3*
Advocacy program	*3*
Therapeutic recreation/socialization program	*3*
Consumer-run drop-in center	*2*
Club house	*2*
Other	*2*
Drop-in center	*1*
Day support program	*1*

NOTE: **Bolded items represent the terms that were selected most frequently by COSPs.*

When asked why "self-help agency" was selected to describe their organization, respondents clarified that the goal is to provide individuals with the necessary tools to support the recovery process, but ultimately, it is up to an individual to help themselves fully recover. "Consumer operated service provider" was also selected most frequently. The respondents explained that the organizations are run by individuals who have received services for a mental health diagnosis [consumers] and provide a specific array of services to anyone who needs those services. However, this finding should be considered cautiously as the researchers referred to these organizations as "consumer operated service providers" throughout the survey and interview, and therefore, respondents may have been more likely to select this choice than the others. When

asked to explain why "independent peer support program" was selected, respondents noted that although they are contracted by DSHS through their associated LMHA, they are still independent organizations that exercise the authority to make decisions regarding their agency.

Due to time constraints, the COSPs were not asked why terms were *not* selected. However, based on responses to other interview questions and two respondents' answers to this question, it seems likely that the terms "drop-in center" and "day support program" were less frequently selected because there may be a negative connotation associated with these organization types. Although the COSPs strive to empower individuals to take charge and become accountable for their lives in a safe, non-judgmental atmosphere, they are *not* a place for people to come to "smoke a cigarette, get something to eat, and hang out." Instead, recovery is seen as a process in which the individual should necessarily be actively engaged.

Of the 13 possible choices, respondents selected anywhere between 1 and 9 terms to describe their organization, with the average being approximately 5.7 terms. This high degree of variability amongst terms used to describe these types of organizations is corroborated by the literature, which refers to COSPs by any number of acronyms (i.e. Consumer Run Agencies or CRAs, Consumer Operated Self-Help Centers or COSHCs, Consumer Provider services or CP services, etc.). The inconsistency of terms and acronyms highlights the need for standardization, which might help researchers, mental health providers, consumers, and even the general populations consider these organizations a cohesive mental health service delivery mechanism.

Role of the COSP in the Public Mental Health System

The COSPs and LMHAs were asked, "What do you think should be the role of a consumer operated service provider in the public mental health system?" during the interview process (Table 4). Similar to the mission statements, most of the LMHAs discussed services that should be provided by the COSPs. Many described the role of COSPs in the public mental health system as offering an additional level of support and empathy, either through peer support groups or one-on-one support, which the LMHAs are sometimes unable to provide. Respondents from both types of organizations noted the importance of COSPs to act as advocates for individuals currently using mental health services. Furthermore, the COSPs expressed that one of their major roles is to alleviate some of the pressure on the overburdened mental health system by providing additional services that the LMHAs cannot or are not currently providing, providing services to individuals on LMHA waitlists, as well as accepting individuals who do not qualify to receive services from the LMHA. In addition, a few of the organizations conveyed an understanding of the geographically expansive and ethnically diverse nature of Texas, making it difficult to generalize the role of COSPs across the state.

In the current assessment, the goal and/or mission of the organization were operationalized by the mission statement, organization type (of the COSPs), and the role of the COSPs in the public

mental health system. Findings suggest that because these two types of organizations express distinct mission statements and envision the COSPs playing differing roles from the LMHAs in the public mental health system their goals do not seem contradictory. In fact, they appear to be highly synergistic, such that the LMHAs focus on enhancing the lives of mental health consumers through the provision of clinical services such as counseling and medication management while the COSPs focus more on the social and emotional needs of mental health consumers through the provision of peer support, community integration, and advocacy.

Table 4. What should be the Role of a COSP in the Mental Health Service System?

COSP: Role of COSP	LMHA: Role of COSP
to provide support, education, listening ... listen to them in a non-judgemental way.	*I think it depends on the organization and the consumer organizations. How could it work here…I would like to see more participation from the consumers, and I would like them to run more activities and assist more people. I would like to see the services expanded. I like the idea of certified peer specialists. We would like to send more individuals to the peer specialist training and then use them as adjunct to the extent that they're comfortable.*
it depends on what's going on in the system you are located, utmost it would be advocating for mental health services and reducing stigma.	*There is definitely a role for that. As an agency we integrate peer specialists into work we do. Through experience we find that consumers respond to peer specialists in a way they don't to clinicians and they are critical to promote recovery. We have peer specialists in the agency and at the AAMHC drop-in center.*
to offer support groups, training on empowerment and basic computer skills, transportation for members, respond to calls from the community - many are from people who don't qualify for the LMHA or have insurance; the LMHA staff have begun to refer people they cannot help to us.	*The peer support groups that Advocates of Abilene provide are very beneficial to those who participate. We don't do that very well at the center. They ebb and flow based on the ability to reimburse. Some of our clients really like the group dynamics of the peer support groups.*
COSPs can play varying roles. Consumer operated programs, if done right, can alleviate the burden on the system by offering programs that can't be offered in the public mental health system. People can't get all the services they need in the public health system, so consumer operated systems give them peer support and mentorship to see what is possible in their lives. This takes pressure off the mental health system by creating alternatives and services not in system and ties in to what mental health system is currently doing. Public mental health system doesn't have all the resources so COSPs can fill some of these gaps.	*I think their role should be in providing support in a way that the provider can't. I know that doctors have a kind of power position that the consumers look up to doctors and I think the Prosumers have more of a peer role. Those roles are very different and the people in those roles provide a different type of relationship/support. This support is important for consumers to have.*
COSP should be integral part of system. It would be good to integrate the COSP and LMHA more (but not necessarily be part of the organization) with each clinic and hospital in Tarrant to offer support groups and peer assistance that would be beneficial (but understands there are few resources to do this).	*One of things that we value is that they are able to offer groups in a wider variety of settings than what we do. They operate in areas we don't have clinics and at night.*

Table 4. What should be the Role of a COSP in the Mental Health Service System? continued

COSP: Role of COSP	LMHA: Role of COSP
Provide centrally located facility that individuals can attend throughout the week that is flexible to them, and is a safe, nonthreatening, nonjudgmental environment surrounded by people who understand what they are going through.	*I really would like to see them be service providers and work hand in hand with the LMHA as well as do some advocacy, provide individual and group therapy, rehab therapy, be able to represent consumers on the treatment team. They should be referral agents and do some networking. It's kind of like its own entity and I would like for it to be more interwoven into the community and the LMHA clinic and maybe the resources can be spread further.*
We've been a liaison to help peers when they have troubles with their doctors or caseworkers, we act in the advocate role. A peer support specialist is very important because that's someone who has a pretty good grasp on their recovery and are able to shine that same light on the system. It gives others hope because a peer support specialist has that experience, they've navigated the system. To someone who is just starting to enter the mental health system, a peer support specialist has that experience…that supportive and advocacy factor. We've always been kind of operated in some of the advocacy and liaison role and help in any way that we can. The main goal is to facilitate hope that they can recover. The worst thing you can do is tell someone they will be sick forever. That's just not true and doesn't give them hope.	*It is hard to say for the whole Texas area because every place is configured differently. Peer provider can play the role of providing extra support and advocacy for a person who has gone through services. The same as for those who get treatment for cancer etc ... the feeling someone has gone through the same thing.*

Operations

Time since Establishment

In the online survey, the COSPs were asked, "How long has your organization been in operation?" Responses ranged from 3 years, 1 month to 17 years, with the mean length of time since establishment being approximately 9 years, 8 months.

Types of Services

A transformed mental health system, according to the President's New Freedom Commission on Mental Health (2003), should emphasize recovery-oriented treatment that goes beyond the traditional mental health service delivery system to include self-help, social support, community resources, and vocational opportunities (Goldstrom et al., 2005). To assess the degree to which COSPs offer recovery-oriented treatment options, COSPs were asked "What types of services does your organization offer consumers?" in the survey. Answer choices were selected from a review of services in the COSP literature and included: one-on-one peer support, facilitating peer support groups, teaching, Wellness Recovery Action Planning (WRAP), recovery education, transportation assistance, vocational/employment assistance, housing assistance, advocacy training, navigating the public mental health system, skills training, accessing community resources, member of case management team, recreation/socialization, warm lines, crisis support, case management, fitness/wellness, computer/technology, education/GED assistance,

and other. Participants were encouraged to select all services that their organization offers to consumers. In the interview, respondents elaborated on their services selected. Of the 20 services listed, COSPs reported providing anywhere between 5 to 18 services, with the average number of services provided by the organizations being approximately 12 services. The types of services provided by the COSPs are summarized in Table 5.

Table 5. Services provided by COSP.

Service	Number of COSPs Providing Service
One-on-one peer support	***6***
Facilitating peer support groups	***6***
Transportation assistance	***6***
Accessing community resources	***6***
Recreation/socialization	***6***
Computer/technology	***6***
Teaching	*5*
Recovery Education	*5*
Navigating the public mental health system	*5*
Wellness Recovery Action Planning (WRAP)	*4*
Vocational/employment assistance	*4*
Housing assistance	*4*
Advocacy training	*4*
Skills training	*4*
Crisis support	*4*
Fitness/wellness	*4*
Other	*4*
Education/GED assistance	*2*
Warm lines	*1*
Member of case management team	*0*
Case management	*0*

NOTE: **Bolded items indicate the services provided most frequently by the COSPs.*

The services provided most frequently by the COSPs were one-on-one peer support, facilitating peer support groups, transportation assistance, accessing community resources, recreation/socialization, and computer/technology services.

One-on-one peer support: When asked to elaborate, respondents explained that the sessions were highly individualized with the topics discussed being dependent on the needs of the consumer seeking the service. This provision of one-on-one peer support by COSPs seems to reflect the notion of patient-centered treatment planning. It was also noted that this service does not necessarily have to occur between COSP staff member and COSP consumer. Rather, they

encourage all consumers to provide this type of peer support, both at the organization and away from it.

Transportation assistance: When asked to elaborate, many respondents commented on the lack of reliable transportation for this population. To overcome this barrier, three COSPs have a program in which members and staff with transportation pick up and drop off those without transportation; one of these COSPs owns a 15 passenger van and they pay a consumer driver to transport members. The remaining three organizations that offer transportation assistance to consumers utilize the public transportation system and either offer consumers discounted bus passes or pay for the bus passes in full. One COSP sometimes borrows a van from the LMHA if available.

Accessing community resources: When asked to further explain, COSPs stated that they provide consumers with resource lists, refer them other organizations such as churches, 211, the Salvation Army, Social Security, Food Stamp office, food pantries, etc., or provide tailored resources based on the needs of the individual directly from the COSP (e.g. professional clothes closet for interviews).

Recreation/socialization services: The COSPs provide a wide variety of these services both at the center and within in the community. Center activities include games, movies, and socials with refreshments. Community-based activities include guided tours, going to the movies, meeting at a restaurant, fishing trips, shopping at a local mall, and attending a county fair. Some COSPs mentioned that activities not occurring at the center are sometimes difficult based on the aforementioned transportation barrier. These types of activities, whether they take place at the organization or within the community, are vital in assisting consumers to build and strengthen their social support networks.

Computer/technology services: A majority of the COSPs reported providing these services, which includes computer access and computer training (e.g. how to use specific applications, build resumes, and search for employment opportunities). In our technologically inundated society, the acquisition of computer skills is essential for consumers to become competitive within the job market.

Respondents were also asked to list the three services that are used most frequently by consumers at their organization. Five of the seven organizations listed peer support (either one-on-one or in group setting) as the most utilized service. Other frequently used services include recreation/socialization, vocational/employment assistance, and education/teaching. Table 6 lists the responses to this question.

Table 6. Top 3 services used most frequently by consumers reported by 7 COSPs

1	2	3
Transportation assistance	*Recreation/socialization*	*Facilitating peer support groups*
One-on-one peer support	*Housing assistance*	*Vocational/employment assistance*
Facilitating peer support groups	*Vocational/employment assistance*	*Accessing community resources*
Vocational/employment assistance	*Skills training (resiliency)*	*Teaching*
One-on-one peer support	*Recreation/socialization*	*Fitness/Wellness*
Facilitating peer support groups	*Educating the public*	*One-on-one peer support*
Facilitating peer support groups	*Education/GED Assistance*	*Recovery Education*

Days and Hours of Operation

All organizations are open at least 4 days a week; five of the organizations are open 5 days a week. No COSPs are open on the weekend. Hours of operation range anywhere from 8:00am to 7:30pm, with one organization facilitating evening activities within the community one night a week. The COSPs are open between 18 and 45 hours a week, with an average of between 27 and 28 hours a week.

Locations of COSP Service Provision

All seven COSPs have an office and provide services at their offices. Four organizations also provide services at the community mental health center offices, which are clinics within the broader LMHA. Five of the COSPs provide services in other community organization offices, such as in area psychiatric hospitals, private hospitals, churches, and local foundations.

Number of Consumers Served by COSPs

Respondents were asked to provide the average number of consumers served by their organization in one day and one week, and the number of unduplicated (counting each consumer once) consumers served in one month. COSPs serve between 10 and 40 consumers (*Mean [M]* =15.86) in one day, between 20 and 200 consumers (*M*=69.57) in one week, and between 30 and 250 unduplicated consumers (*M*=98.57) in one month.

Referral Entities

The COSPs were presented with the following statement: “We serve consumers that are:” and asked to select all choices that apply. The answer choices were “referred by the Community Mental Health Center (CMHC),” “referred by other community entities,” and “self-referred.” All COSPs selected all answer choices, which highlights the openness of these types of organizations.

When asked to list other community entities that refer consumers to their organization, respondents listed several entities such as adult probations, 211, Mental Health America (MHA), National Alliance of Mental Illness (NAMI), churches, universities, local foundations, the Department of Assistive and Rehabilitative Services (DARS), Goodwill, and the Salvation Army, among others.

In the interview portion of the assessment, many organizations touched on the fact that they will provide services to any individual with mental health needs, regardless of diagnosis or Resiliency and Disease Management (RDM) Service Package. As mentioned previously, many organizations mentioned that one potential role of their organization within the public mental health system is to alleviate some of the pressure on the overburdened LMHA. Because the COSPs appear to maintain an "open-door policy" they might be able to support some individuals who would not be able to receive services otherwise, e.g. some LMHAs refer consumers to COSPs for services while they are on the LMHA waitlist.

Referral Process

Both the COSPs and the LMHAs were asked about the referral process that occurs in the direction of LMHA to COSP. None of the organizations currently have a formal referral process in place for LMHA referrals or other community entity referrals, but the relationships and communication with staff at these organizations appears related to referrals.

Most LMHAs have a stack of brochures or pamphlets describing the affiliated COSP and the services they provide in the reception area for consumers to take, if interested. In addition, caseworkers sometimes refer consumers to the COSP. Psychiatrists may also refer consumers, although to a lesser extent than the caseworkers. None of the LMHAs track the number of individuals they refer to the COSP because they reported not having had a reason to set up a tracking mechanism. Some LMHAs did say that such a tracking mechanism could be set up if necessary. Several COSPs mentioned that they ask individuals, either verbally or on their intake paperwork, what organization referred him/her to their services.

Non-Profit Status

A 501(c)(3) organization is a non-profit organization exempt from paying federal income tax that operates for religious, charitable, scientific, literary, or education purposes. Of the seven COSPs, five have been incorporated as an independent 501(c)(3) entity and two have not. One of the organizations utilizes the non-profit status of an umbrella agency. This umbrella agency acts as the COSP's trustee, and provides the COSP an opportunity to apply for grants that are reserved for non-profit entities. This organization indicated that they understood the value of 501(c)(3) status and had set aside funds in their budget to apply at some point in the future.

The five COSPs who have a non-profit organization designation, have been established from between 4 and 13 years, with the average being approximately 9 years. These organizations noted that the actual process of filing for non-profit status was not difficult; however, the paperwork to maintain status per IRS rules can be human resource time-consuming and tedious. Cost did not seem to be a barrier. The two organizations who have not been established as independent 501(c)(3) organizations recognize the benefits of doing so but have not because they

have not found the time or because they do not to want handle the many requirements associated with filing.

Board of Directors

COSP

Respondents were asked if they had a board of directors, the size of their board, and the number of consumers or family members of consumers included on their boards. Six of the seven COSPs have a Board of Directors, who provide support and guidance regarding the future of the organization, particularly financial guidance. Most of the boards meet on a monthly basis, and are at least "fairly active" in COSP operations. Of these, the size of the board ranges from 5 to 12 members, with an average size of approximately 7 members. The six boards are comprised of 33% to 100% consumers; consumers make up a majority (at least 60%) of the board at five of the six organizations. Three of the six boards include family members of consumers on their board (range from 11% to 43% family members). One COSP does not have a Board of Directors or any other kind of advisory board.

LMHA

The LMHAs were asked if their board included consumer members. Five of the seven LMHAs do not include consumers on their Board of Directors. Only one LMHA stated having one consumer on their board. One organization was unsure whether or not their board included consumers. Some of these organizations mentioned that although they are interested in including consumers on their boards, either there is lack of interest by consumers or by the organization or they have trouble retaining consumers on their boards. Six of the seven LMHAs include family members of consumers on their boards and one was unsure of the inclusion of family members on their board.

Although consumer involvement on the LMHAs' Board of Directors could be increased, six of the seven LMHAs do have a consumer or family advisory committee, a group which provides feedback on the services provided by the LMHA. These committees ensure that the services offered are high quality and cost-effective and make recommendations to the board if there are areas which could be improved. According to DSHS regulations, each LMHA is required to "appoint, charge and support one or more Planning and Network Advisory Committee (PNAC) necessary to perform the committee's advisory functions" (Department of State Health Services, 2010). These committees are expected to have at least nine members and be comprised of at least 50% consumers or family members of consumers. It is assumed that all seven LMHAs participating in the current assessment have a PNAC; however, one respondent seemed to be unaware of this committee. Thus, the LMHAs should strive to increase awareness of the PNAC throughout to organization in order to enhance consumer involvement and recovery-oriented practices.

Organizational Structure

In the interview, the COSPs were asked if they have an organizational chart. Three of the seven organizations responded that they did and that they would send it to the researchers. The four remaining COSPs were asked to describe their organizational structure. Two described their organizational structure as the board being the governing body over the Executive Director and the Executive Director providing guidance and supervision to the rest of the staff and volunteers.

Support from LMHA

The LMHAs and COSPs were asked what type of support (if any) the LMHA staff provides the COSP staff. Respondents from the LMHAs tended to list more areas of support than the COSPs. From the perspective of the LMHAs, frequently listed areas of support include financial guidance, in-kind donations, problem-solving with staff members to resolve issues, staff training and education, and mentoring. From the perspective of the COSPS, LMHAs mainly serve as a referral source and a funding mechanism, providing both monetary support (through their contract) and in-kind donations such as the physical office space and utilities.

Staffing

Composition of Positions

The COSPs have anywhere from 3 to 27 individuals working at their organization. Two COSPs have 1 full-time staff member and one has 2 full-time staff members. Six of the COSPs have between 1 and 12 part-time staff members. Five COSPs have between 1 and 15 volunteer positions and one COSP said they had volunteer positions in the past, but do not currently have any volunteers at their organization due to poor retention. Approximately 5.6% of the total positions are full-time, 47.9% are part-time, and 46.5% are volunteer positions.

Of the COSPs with full-time staff members, these are generally the Executive Directors. In one case, the Program Director is a full-time employee. These individuals are paid anywhere from minimum wage (currently $7.25 an hour) to $24,000 a year. Part-time staff members are employed as Center Directors, Program Coordinators, Office Managers/Secretaries, Bookkeepers, Peer Specialists, Group Facilitators, and Van Drivers and are paid between $50 a month and $8,400 a year. Volunteers are unpaid staff members and are employed as Assistant Executive Directors, Center Managers, Office Mangers, Computer Laboratory Technicians, Data Entry Specialists, Administrators, Peer Mentors/Journeymen, Human Resource Managers, and Janitors. As an indirect comparison, the estimated median income for a family of four in Texas is $56,606 (http://www.hhsc.state.tx.us/research/dssi/ESI/StateMedianFamilyIncome.html).

Of the organizations that utilize volunteers, most recruit from COSP members and have developed a strengths-based approach in terms of volunteer utilization; if a member appears to excel in a particular area, they focus on training in that area. Other members show an interest in becoming more involved and COSPs will place them in volunteer positions at the food bank or

administrative positions within the agency. Eventually, some volunteers become paid employees at the COSP or have gained enough experience that they seek employment outside the organization. In general, most do not remain as volunteers long-term as they move on in their recovery.

Peer/Consumer Staff

Six of the LMHA respondents stated that they currently employ between 1 and 13 consumer or peer staff members. Three of these organizations employ consumer staff in peer specialist positions, whose tasks include facilitating peer support groups, advocating for consumers in treatment planning, and providing one-on-one peer support. Two LMHAs employ consumer staff in case management positions and mainly provide one-on-one peer support or help engage consumers who may be difficult to contact. One respondent said that although they do have employees with a mental health diagnosis, they do not identify themselves as such in their daily work.

The COSPs were also asked to disclose the number of consumer staff within their organization. Five organizations have staff comprised of 100% consumers. One COSP reported having a staff made up of 75% consumers. One respondent stated that they did not currently have any consumers employed at their organization, which is unusual for a typically defined consumer operated service provider. Of these six organizations, three currently have job descriptions for their consumer staff, one is currently working on developing job descriptions, and two have not established job descriptions for their consumer staff. The COSPs were also asked, “Is the director a mental health consumer (an individual who has received services for a mental health diagnosis)?” Five organizations responded “yes” to this question, one indicated the director is no longer a consumer, but a family member, and one responded “no.”

Certified Peer Specialists

Most organizations (4 COSPs and 5 LMHAs) have staff that attended the Via Hope Peer Specialist Training. The number of staff certified as peer specialists ranges from 1 to 10. Some organizations noted that some staff were certified by the Depression Bipolar Support Alliance (DBSA) or through NAMI’s Peer-to-Peer Training. One LMHA commented that they rely on their affiliated COSP to provide peer support services, therefore they do not currently have any peer specialists working directly for their center. There seems to be a high level of interest in the Via Hope Peer Specialist Training and Certification, as all seven COSPs expressed some sort of interest, with most suggesting they would like staff members to apply for upcoming trainings. One organization stated they had just recently become aware of the program, indicating a need to increase awareness of the program.

Career Ladder or Opportunities for Advancement

In the interview, the COSPs were asked, “Does your organization have a career ladder or opportunities for advancement for staff and/or volunteers?” Three organizations responded that they did have a career ladder, such that many individuals begin working as volunteers and eventually move up within the organization. One organization has a structured career ladder with different levels of volunteerism. Four COSPs did not have a career ladder at the time of the interview, citing barriers such as a lack of funding and too few employees.

Working after the Recovery Journey Begins

The COSPs were asked what kind of work people go on to do after beginning their recovery journey. Overall, the COSPs do not track this information at a high level of detail, but provided anecdotal responses. Many responded that the type of work people go into tends to depend on the individual seeking employment and their skills and / or level of recovery; some individuals find employment at thrift or grocery stores, some go into helping professions, some become involved in technology, some return to employment similar to what they did before they were affected by mental illness, for example, janitorial or medical work. One COSP mentioned that they send many individuals to the Department of Assistive and Rehabilitative Services (DARS), who have a supportive employment program. Many respondents mentioned the importance work can provide in an individual’s life who has struggled with mental illness; it can provide one with a sense of empowerment and meaning.

Funding

Annual Budget for COSPs

The annual budget for the COSPs is between $23,760 and $135,000, with a mean annual budget of $65,756. The funding received through the DSHS subcontract with the LMHA accounts for anywhere between 48% and 100% of the annual budgets. In dollar amounts, the LMHA subcontracts range from $23,760 to $71,500, according to the LMHA respondents. Staff members are paid through the DSHS contracts. Some COSPs raise supplementary money through individual donations, local universities, state hospitals, foundations, grants and the provision of training. In addition to monetary funding, many organizations said they receive in-kind donations as well, including office space, meeting facilities, utilities, general office supplies, printing costs, and computers.

COSPs were asked “How does your organization receive its funding?” and were asked to select “upfront monthly/quarterly payments for services,” “monthly or quarterly reimbursement for services,” “fee for services,” or “other”. The most common payment arrangement is upfront monthly/quarterly payments, with five organizations receiving funding through this method, followed by reimbursement for services with three organizations, and fee for service and other (membership donations) with 1 organization each. Because some organizations receive money from a variety of sources, they may have selected more than one payment method. In the interview, respondents were asked if this payment arrangement works for their center. Those

receiving upfront payments were generally satisfied with the payment arrangement, with the exception of late payments. On the other hand, those who are paid through monthly or quarterly reimbursement for services find this method difficult because it requires having a certain amount of money on hand available. Because these organizations operate on such low budgets already, they often do not have money reserved. Thus, the financial burden falls on the shoulders of the Executive Director. One respondent reported having to pay for certain expenses out-of-pocket and then waiting to be reimbursed.

Grants and Funding Opportunities

Six of the COSPs are currently alerted to grant or funding opportunities mainly via emails from organizations such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Hogg Foundation, NAMI, various sources at DSHS, and the LMHA listserv. A few respondents mentioned occasionally conducting internet searches to look for these opportunities. One organization is not currently alerted to grant or funding opportunities, but knows how to become alerted. This organization noted that searching for funding opportunities is a time intensive process and with so many other tasks at hand, this one is not necessarily a priority. Further, this particular COSP expressed an interest in organizing a research study examining the cost-effectiveness of COSPs. Although there is much anecdotal evidence that these organizations work, there is a need to test effectiveness empirically; obtaining funding would be instrumental in initiating research efforts.

In terms of applying for federal, state, or local grants, six of the COSPs have applied in the past. Again, one organization has never applied for a grant for reasons related to time-constraints and resources. About half of the organizations have applied for grants through the Hogg Foundation and have been satisfied with the process. Organizations have also applied to grants from the NAMI Support, Technical Assistance, and Resource (STAR) Center, local organizations and foundations, and United Way. One organization mentioned applying for a grant through DARS, which was a difficult and time-consuming process. Another organization commented on the difficulties associated with applying to state and federal grants and as a result has almost put all funding efforts into applying for local grants only.

Barriers

Besides time, a variety of barriers exist in applying for grants or other funding. The COSPs were asked, “What barriers have you experienced in the application process for obtaining funding (either a grant award or contract)?” Respondents were encouraged to check any of the following answer choices that apply to their organization: application window too narrow/not enough notice received, inexperience at writing proposals or applications, unable to raise match, applicant qualifications were too restrictive, the system was biased against organizations like ours, applications are not a good fit for our organization, overhead allowance is insufficient to support our organization, funding amount to small/grant period too short for amount of

implementation effort required, few funding opportunities for organizations like ours, 501(c)(3) status was required to apply and we do not have 501(c)(3) status, our organization would have to apply through the local mental health authority and this would be difficult, and other. The COSPs selected between 1 and 6 barriers, with the average being approximately 3.4 barriers. Table 7 below summarizes COSP responses to this question.

Table 7. Barriers in the application process for obtaining funding.

Barrier	Number of COSPs Encountering Barrier
few funding opportunities for organizations like ours	***4***
application window too narrow/not enough notice received	***3***
inexperience at writing proposals or applications	***3***
applications are not a good fit for our organization	***3***
other	***3***
applicant qualifications were too restrictive	*2*
unable to raise match	*1*
the system was biased against organizations like ours	*1*
overhead allowance is insufficient to support our organization	*1*
funding amount to small/grant period too short for amount of implementation effort required	*1*
501(c)(3) status was required to apply and we do not have 501(c)(3) status	*1*
our organization would have to apply through the local mental health authority and this would be difficult	*1*

NOTE: **Bolded items represent the barriers that were selected most frequently by COSPs.*

The biggest barrier in applying for funding seems to be a lack of funding opportunities for consumer organizations. As you can see in Table 7, other frequently selected barriers were application window too narrow/not enough notice received, inexperience at writing proposals or applications, applications are not a good fit for our organization, and other. When asked to specify "other", respondents mentioned barriers such as wordy or confusing documentation, not having necessary documents to apply, lack of resources to write grants, and lack of grants that will assist organizations in becoming financially sustainable over time (i.e., grants are a one-time, time-limited source of funding).

In order to overcome these barriers, access to grant opportunities should be enhanced by receiving notifications far in advance for a wide variety of grants, both in terms of funding amount and topic area, and networking with other peer support groups. Organizations expressed an interest in the development of a system that sends out a notification regarding all available, relevant funding opportunities for organizations like COSPs. Irrelevant grants and funding opportunities that are not applicable to these organizations should be filtered out, as these organizations do not want to modify their organization based on funding opportunities. Rather,

they would like to apply for grants that are applicable to what they are currently doing. In addition, time management and/or grant writing courses/workshops could be utilized in order to make time to write competitive applications.

Contract Monitoring

The LMHAs are required by DSHS to monitor the contract with the COSPs on at least a quarterly basis. Individuals or units within the LMHA that monitor the contract include the CEO, CFO, Mental Health Director, Director of Programs, Director of Quality Management (QM) Department, the QM department, Consumer Liaison, and the Advisory Committee. The COSP generally sends a monthly report to the LMHA, summarizing the activities that took place, services provided, money spent, and the number of consumers served. After receiving the monthly report, the LMHA subsequently sends a quarterly report to DSHS. Most organizations report that monitoring staff generally visit the COSP once a quarter to make sure operations are running smoothly, expenditures are in place, as well as to gain a sense of satisfaction and effectiveness associated with the COSP. If negative findings emerge during the monitoring process, most organizations discuss the issue(s) with the ED of the COSP and the two organizations will problem-solve together to develop a solution. The LMHAs were asked what happens if the COSP overspends or underspends their funding allotment. In terms of underspending, the LMHAs noted that that rarely happens, but if it does, the COSP either purchases items that they need or they pay it back. On the other hand, if the COSP overspends their funding allotment, most LMHAs stated the COSPs are held accountable for making up the difference, through other funding sources or fundraising activities.

Communication

COSP

Respondents from the COSP were asked how often they talk to different local, state, and national organizations, with answer choices being daily, weekly, monthly, quarterly, only when problems arise and never. Table 8 summarizes the COSP responses to this question. The percentages in the table represent the percentage of COSPs that selected this answer choice.

These findings indicate that COSP respondents generally communicate most often with staff at the LMHA and least frequently with staff at national organizations that support consumer/family efforts, with over half the respondents never talking to these types of organizations. COSP respondents reported a high percentage of monthly contact with DSHS staff, but this is a recent occurrence coinciding with the monthly COSP-LMHA calls held by DSHS. In the interviews, COSPs were also asked about their communication with co-located state psychiatric hospitals. It seems as though only one COSP has a strong relationship with the state hospitals, as they contract peer support services to the local hospitals. Increased communication between the COSPs may facilitate collaboration and learning opportunities while strengthening the consumer

movement. Furthermore, increased awareness of these organizations at the national, state, and local level may enhance partnership and networking opportunities.

Table 8. COSP Frequency of Communication.

How often do you talk with:	Daily	Weekly	Monthly	Quarterly	Only when problems arise	Never
Staff at the LMHA?	14.3%	28.6%	57.1%	–	–	–
Staff at DSHS?	–	–	71.4%	14.3%	–	14.3%
Director/Staff at other community level COS organizations?	–	14.3%	42.9%	14.3%	14.3%	14.3%
Director/Staff at state level consumer/family organizations? Missing – 14.3%	–	–	57.1%	28.6%	–	–
Staff of national organizations that support consumer/family efforts?	–	14.3%	–	14.3%	14.3%	57.1%
Other local community organizations? Missing – 14.3%	–	42.9%	28.6%	–	–	14.3%

LMHA

Respondents from the LMHA were also asked the frequency with which they communicate with the COSP Director and COSP staff. Again, answer choices ranged from daily to never. Responses are summarized in Table 9 below.

Table 9. LMHA Frequency of Communication.

How often do you talk with:	*Daily*	*Weekly*	*Monthly*	*Quarterly*	*Only when problems arise*	*Never*
COSP Director?	–	*42.9%*	*42.9%*	*14.3%*	–	–
COSP Staff?	–	*14.3%*	*14.3%*	*42.9%*	*14.3%*	*14.3%*

Most LMHAs report talking with the COSP Director on a weekly or monthly basis, with one LMHA reporting talking with the COSP Director on a quarterly basis. There is a higher degree of variability in terms of frequency of communication between the LMHA and COSP staff. Three of the LMHAs report communication on a quarterly basis and one LMHA each reporting weekly, monthly, only when problems arise, and never.

The LMHAs were also asked how the COSP staff addresses issues or problems that may arise. Most centers stated that COSP staff issues are generally discussed internally, either with the Director or amongst themselves in staff meetings. Some LMHAs added they will assist with problems if it is something the COSP cannot handle independently. Enhanced communication

between the LMHAs and COSP staff may help the LMHA respondents gain a better understanding of the day-to-day operations at the COSP.

Contact: Level of Ease and Responsiveness between Organizations

COSPs were also asked questions regarding the level of ease associated with contacting the LMHA as well as the responsiveness of the LMHA. Six COSPs reported that contacting their LMHA is very easy, one reported moderately easy. Five of the COSPs reported that their calls and emails to the LMHA are returned the day they are placed, two reported they are returned within the week. One COSP even mentioned that communication has recently improved; previously there was a delay in response time, but now calls/emails are returned promptly, resulting in the COSP feeling like a valued asset.

Like the COSPs, the LMHAs were asked about the ease of contacting the COSP via telephone or email as well as the responsiveness of the COSP in returning phone calls or emails. Six LMHAs described the COSPs as being "very easy" to contact, and one described it as being "moderately easy." In terms of responsiveness, four LMHAs reported calls and emails being returned the day it is placed and three reported they are returned within the week.

Integration of Services

All respondents were asked the degree to which the work of their organization is integrated with the work of the organization they are affiliated with. The answer choices were not at all integrated (for example, we provide our services and they provide theirs), somewhat integrated (for example, we communicate with center staff when the consumers in our organizations have a need or crisis), frequently integrated (for example, we communicate frequently with center staff about the needs of consumers we share), and very integrated (for example, we are part of the center's case management team). Table 10 summarizes the organization's responses to this question.

Table 10. Service Integration between COSPs and LMHAs

	Not at all integrated	*Somewhat integrated*	*Frequently Integrated*	*Very Integrated*
COSP	*14.3%*	*42.9%*	*42.9%*	–
LMHA	*14.3%*	*57.1%*	*28.6%*	–

None of the organizations reported their work as being very integrated with their affiliated organization. Three COSPs and two LMHAs described their work as being frequently integrated, three COSPs and four LMHAs reported their work as being somewhat integrated, and one COSP and one LMHA selected not at all integrated. Interestingly, the two organizations selecting not at all integrated are not affiliated with one another.

In the interview, the organizations were asked to explain their level of integration. The COSP that responded not at all integrated further explains that although they partner with the LMHA,

they are separate entities. The LMHA that selected not at all integrated expressed an interest in integrating the COSP services with the services of a co-located clinic. The organizations that described their work as being somewhat integrated clarified their responses by explaining that there is a mutual referral process in place, both organizations provide information to consumers about their affiliated organization, and the COSP occasionally presents programs to LMHA staff and consumers. The COSPs describing their work as frequently integrated reported involvement in training new employees on recovery concepts and serving on various LMHA boards and committees. One COSP mentioned that there is room for improvement in terms of integration between the two organizations. The LMHAs selecting frequently integrated further clarified their answers by discussing the frequent communication amongst the two organizations; one LMHA even discussed joint social engagements.

One common theme emerging throughout all explanations, regardless of organization type and level of integration, was the notion that although these organizations partner with one another, they are separate entities. Thus, although most (if not all) organizations understand the importance of collaboration between traditional and peer-run mental health services, they also value the unique contributions of each organization type and strive to maintain their distinct identities and values.

Communicating Services

The COSPs were asked to identify the ways in which they communicate their services to individual consumers, family members, and the community. Answer choices included the following: we have a website, we network, our organization is included as a link on the LMHA website, our organization is included as a link on other community websites, we serve on various committees and/or boards in the community, we speak about our organization at various community organization meetings, word of mouth, and other. Responses are summarized in Table 11.

The most commonly used strategy for communicating COSP services is word of mouth. All organizations reporting using this technique, which may happen through a variety of different avenues such as consumer to consumer, family member to family member, staff to consumer, etc. The second most commonly used strategy is through networking. In the interview, the COSPs were asked how they network. Responses primarily consisted of talking to people around the community at a variety of meetings, such as NAMI, church, and Salvation Army. One organization explained that they deliver their monthly newsletter to a number of different organizations throughout the community, which facilitates networking opportunities. Another organization expressed a need to enhance their networking efforts. “Other” communication strategies include newsletters, brochures, and newspaper advertisements. Unfortunately, the communication technique used least commonly is the inclusion of the organization as a link on the LMHA website. However, two organizations do not have a website and one organization’s

website is not currently up and running. One area that could be improved is advertising services through the internet. Technical assistance should be provided to the organizations that do not currently have a website and to the organization whose website is not currently functioning. Furthermore, communication about services could be enhanced if the LMHA and other organizations included a link to the COSP website.

Table 11. Communication of COSP Services Provided.

Communication Technique	*Number of COSPs Utilizing Communication Technique*
Word of mouth	***7***
We network	***6***
We have a website	*5*
We speak about our organization and its services at various community organization meetings	*5*
Other	*5*
Our organization is included as a link on other community websites	*4*
We serve on various committees and/or board in the community	*4*
Our organization is included as a link on the LMHA website	*3*

NOTE: **Bolded items indicate the communication strategies used most commonly by the COSPs.*

In addition, the LMHAs were asked if they communicate COSP services to their consumers. All seven LMHAs stated that they do communicate services to consumers and when asked to explain how they do this, they described the communication process as being both verbally and through written materials such as brochures, pamphlets, or newsletters. Most centers indicated it is primarily caseworkers who communicate the COSP services to consumers in the referral process, and both groups indicated that these are often relationship-based between particular LMHA and COSP staff. Although it is significant that the LMHAs are using a combination of written and verbal communication to advertise COSP services to consumers, the COSP would probably benefit from a more formal and active communication process with the LMHA.

Outcomes and Impact of COSPs in the Community

Tracking Services Provided

Six out of seven COSPs reported that they do track the number of services provided using various methods such as intake paperwork, class attendance sheets, and telephone logs. Two of the organizations reported the use of electronic records for this purpose. One COSP even reported in-detail tracking records which include the date, the event or service, and a paragraph explaining what was done; this is done in support of contractual stipulations. The only COSP that did not track services reported that they had never been asked to do so. Five out of seven LMHAs track the services provided by their associated COSP.

Tracking Consumers Served

All COSPs reported that they track the number of consumers served. Similar to tracking of services, most reported that they used sign-in sheets and attendance logs to obtain this information. Two COSPs said that they maintained electronic records of these data and another said that it reverted to paper records until they attain funds to update their electronic tracking software. In contrast, only five out of seven LMHAs track consumers utilizing COSP services.

Program Success

When asked how they knew if their program was successful, COSP representatives said that they used either quantitative or qualitative (or both) methods of evaluation. Two of the organizations reported quantitative only methods including attendance, increases in referrals, and number of journeymen gaining employment. Three organizations reported using both quantitative data (i.e., attendance and clinical outcomes) and qualitative data (i.e., surveys, feedback, and written testimonials). Two organizations reported using only qualitative, anecdotal methods for evaluating success including observing the attitudes of consumers and simply witnessing outcomes.

COSPs measure their outcomes via: satisfaction reports, services utilized, anecdotal feedback, needs self-assessments, consumer essays, and verbal communication. In measuring the success of services provided, most COSPs reported that they generally lacked a way to measure the impact/worth of such services. The two organizations that reported attempts to measure service success, used attendance and goals; however, they did not have an evaluatory process in place. Out of seven, only one COSP reported confidently that they had an adequate measure of service success (attendance). Two of the COSPs expressed a desire to utilize empirical study methods including statistical testing.

Communicating Organization's Effectiveness to Stakeholders

When asked how they communicated their organization's effectiveness to board members, grant funders, and other stakeholders, COSPs said that they utilized reports at board meetings, annual reports, anecdotes, and attendance records. One reported that they were in the process of reviewing and reporting survey results to convey organizational effectiveness.

Consumer Outcomes related to COSPs and LMHAs

All COSPs and LMHAs thought that consumers had better outcomes when they utilized services of both types of organizations than if they had used only the traditional provider services of LMHAs. Reasons for this included aspects which were almost exclusive to COSPs such as:

- non-judgmental social support,
- individual engagement,
- experiential knowledge of consumer-providers,
- community activities,

- skills training,
- resources offered in a community setting,
- transportation services, and
- mentor relationships.

When the organizations were asked if they thought that consumers had better outcomes with both types of services than with COSPs alone, only one COSP expressed reservations about this statement, but explained that the slower, more stable benefits of consumer-provided services could not really work without the capacity of the LMHA to alleviate symptoms. In other words, an integration of the two types of organizations was needed. Other reasons given for the combinatory benefits were aspects of mental health care which only the LMHAs have the capacity to provide, including psychiatrists, medications, specific non-pharmacological treatments, access to housing, medical/clinical skills, and outpatient services. Generally, the organizations agreed that the best model for care is collaborative.

Measuring COSP Success through LMHA Contract Requirements

LMHAs were asked what measures were used in evaluating success in meeting contract requirements. Only one representative was unsure of how this was done. Most other organizations (*n*=5) reported using a list of outcomes, which were provided by DSHS as contract attachments. One LMHA said that they reviewed a monthly report submitted by their associated COSP.

LMHA contract outcomes include items such as: daily census, number of peer support groups, minimum number of consumer employees, providing outreach services, etc. When LMHAs were asked about how they knew if their COSPs were successful and how they measured the success of their services, they were mixed on whether they used objective or less formal, subjective measures. Some reported that they used only objective criteria including numbers, budgets, and contract outcomes. Others reported using anecdotal measures, progress notes, site visits, and verbal communication.

Immediate and Ongoing Training and Technical Assistance Needs

Because Via Hope was charged with providing training and technical assistance (TTA) to the COSPs participating in the current needs assessment, it is important to include the organizations in the development of the TTA that they will receive. Therefore, both organizations were asked to identify areas the COSP would benefit in developing capacity as well as the content areas both COSP and LMHA staff would benefit from receiving TTA. For the purposes of the needs assessment, the researchers have defined TTA as any number of activities (face to face training, telephone calls, teleconference, webconference, resource identification, on-site visits and meetings) that are intended to assist organizations and staff with learning new skills to improve the services provided by the organization, consumer outcomes, and the sustainability of the organization.

Training and Technical Assistance Capacity Areas for COSP

The Organizational Capacity Framework (Wituk et al., 2008) categorizes activities essential to operating a nonprofit into four core areas: technical, management, adaptive, and leadership. Technical capacity refers to the ability to handle day to day operations. Management capacity refers to ability to utilize its resources effectively and respond to issues as they arise. Adaptive capacity is the ability to monitor, assess, and respond to internal and external changes. Lastly, leadership capacity is the leader's ability to identify and implement steps necessary to reach an organization's mission. Different types of TTA and associated activities fall under one of these broader capacity areas. On the survey, we asked the 14 respondents to select the activities falling under each capacity areas that the COSP would benefit from receiving. One COSP did not select any of the answer choices, but emphasized (in the "other" explanation box) the importance of developing a partnership with DARS as well as the funding provided by DSHS through the LMHAs. Likewise, one LMHA did not select any of the answer choices, but reported that they thought the COSP was handling all areas effectively. Therefore, the results were based on the responses of 6 COSPs and 6 LMHAs. Table 12 summarizes the TTA activities related to capacity development for the COSPs, as identified by both organization types. Table 13 summarizes the broader organizational capacity needs for the COSPs.

The most frequently requested TTA areas for COSP capacity development were grant writing, fundraising, transportation, and volunteer development. Because the COSPs receive such a small amount of funding through DSHS, it is not surprising that the top two TTA needs are related to sustainability. This finding is corroborated multiple times throughout the needs assessment. For instance, one of the primary barriers in applying for funding was inexperience in writing grant proposals (see Table 7). As funding opportunities become more competitive, it is imperative that COSPs enhance grant writing and fundraising capabilities (Wituk et al., 2008).

Six of the twelve organizations expressed a need to provide transportation assistance for their consumers because they often do not have a personal vehicle and public transportation can be expensive and difficult to navigate; some COSPs are located in rural areas and do not have access to public transportation. When asked what services are offered to consumers at their organization (see Table 5), six of the seven COSPs selected transportation assistance. Thus, facilitating transportation appears to be an important issue for COSPs.

Table 12. Organizational Capacity TTA for COSPs.

Type of TTA and Activities	*Organizational Capacity*	*TTA Requested (frequencies and percentages)*		
		COSP	*LMHA*	*Total*
Grant writing (e.g. organizing and drafting grant applications)	*Technical*	***5 (10.4%)***	***6 (12.2%)***	*11 (11.3%)*
Fundraising (e.g. seeking funds, applying for funds, negotiating contracts)	*Adaptive*	*4 (4.2%)*	***5 (10.2%)***	*9 (9.3%)*
Transportation (e.g. purchasing vehicles, providing transportation to events)	*Technical*	***4 (8.3%)***	*3 (6.1%)*	*7 (7.2%)*
Volunteer development (e.g. identifying new ways for volunteers to contribute to the program, developing reward systems for volunteers)	*Management*	***4 (8.3%)***	*3 (6.1%)*	*7 (7.2%)*
Public awareness (e.g. informing about opportunities to advocate for mental health at conferences and schools)	*Technical*	*3 (6.3%)*	*3 (6.1%)*	*6 (6.2%)*
Business management (e.g. maintaining hours of operation, financial reporting)	*Management*	*2 (4.2%)*	***4 (8.2%)***	*6 (6.2%)*
Strategic planning (e.g. establishing long-term goals, writing a business plan)	*Adaptive*	*3 (6.3%)*	*3 (6.1%)*	*6 (6.2%)*
Policy development (e.g. helping develop/modify bylaws)	*Management*	*2 (4.2%)*	*3 (6.1%)*	*5 (5.2%)*
Board development (e.g. leadership and board training, team building)	*Leadership*	*3 (6.3%)*	*2 (4.1%)*	*5 (5.2%)*
Increasing membership (e.g. developing ideas for new member recruitment)	*Management*	*2 (4.2%)*	*2 (4.1%)*	*4 (4.1%)*
Partnership relations (e.g. writing business letters, networking with organizations)	*Adaptive*	*1 (2.1%)*	*3 (6.1%)*	*4 (4.1%)*
Using information and data to tell your organization's story (results and outcomes)	*Leadership*	*2 (4.2%)*	*2 (4.1%)*	*4 (4.1%)*
Quarterly reporting (e.g. organizing materials for writing reports, document formatting)	*Technical*	*1 (2.1%)*	*2 (4.1%)*	*3 (3.1%)*
Conflict resolution (e.g. mediation, helping board members reach negotiations)	*Management*	*1 (2.1%)*	*2 (4.1%)*	*3 (3.1%)*
Staffing issues (e.g. teaching board about hiring process, developing job descriptions)	*Management*	*2 (4.2%)*	*1 (2.0%)*	*3 (3.1%)*
Activities related to maintaining nonprofit status (e.g. completing IRS forms, filing for incorporation with the state)	*Adaptive*	*1 (2.1%)*	*2 (4.1%)*	*3 (3.1%)*
Obtaining 501(c)(3) status	*Leadership*	*1 (2.1%)*	*2 (4.1%)*	*3 (3.1%)*
Financial management (e.g. providing workshops on balancing budgets and checkbooks)	*Technical*	*1 (2.1%)*	*1 (2.0%)*	*2 (2.1%)*
Computer issues (e.g. updating computers, installing software, creating e-mail accounts)	*Technical*	*1 (2.1%)*	–	*1 (1.0%)*
Activity planning (e.g. creating itineraries and timelines for planned events)	*Adaptive*	–	–	–
Other	*Other*	*5 (10.4%)*	–	*5 (5.2%)*
Total number of requests for TTA		***48 (100%)***	***49 (100%)***	***97 (100%)***

Note: Top three topics reported by the COSP and LMHA are in bold.

Table 13. Organizational Capacity for COSPs.

Organizational Capacity	*TTA Requested (frequencies and percentages)*		
	COSP	*LMHA*	*Total*
Technical	***15 (31.3%)***	***15 (30.6%)***	***30 (30.9%)***
Management	*13 (27.1%)*	***15 (30.6%)***	*28 (28.9%)*
Adaptive	*9 (18.8%)*	*13 (26.5%)*	*21 (21.6%)*
Leadership	*6 (12.5%)*	*6 (12.2%)*	*12 (12.4%)*
Other	*5 (10.4%)*	–	*5 (5.2%)*
Total number of requests for TTA	***48 (100%)***	***49 (100%)***	***97 (100%)***

Half of the organizations also selected a need for TTA in volunteer development. Again, due to the lack of funding, COSPs must rely heavily on volunteer staff in order to keep their organizations in operation. Like paid staff, organizations would like to develop ways to utilize each volunteer to their full potential and to offer individuals rewards for a job well done as a way to retain volunteers and to provide a source of motivation. Interestingly, no organizations reported the need for COSP activity planning. Based on this finding as well as the fact that the COSPs offer consumers a wide variety of services and activities, it seems as though are relatively proficient at planning events that suit consumers' needs.

Two of the top four TTA requests fall under the technical capacity (e.g., grant writing and transportation), one falls under the adaptive capacity (e.g., fundraising) and one falls under the management capacity (e.g., volunteer development). When examining the overall requests for TTA for each capacity area, technical capacity emerges as the most requested, followed closely by management capacity, adaptive capacity, and lastly leadership capacity (Table 13). In the interview, organizations were asked to identify three TTA areas that they feel the COSP would benefit the *most* from receiving (Table 14). COSPs were more than twice as likely to report that COSPs would benefit the most from receiving TTA in a technical capacity area (in terms of which types of TTA the COSPs would benefit the most from receiving) as the LMHAs; 12 out of the 19 (63.2%) COSP responses to this question were areas of technical capacity, compared to only five of the 18 (27.8%) LMHA responses. The pattern was reversed for management capacity. The LMHAs were more than three times as likely (38.9% to 10.5%) to report that COSPs would benefit the most from TTA in management capacity areas. Wituk and colleagues (2008) explain that as COSP leaders become more familiar with available technical assistance, they may be more inclined to request assistance in the technical capacity area. On the other hand, the LMHAs may perceive COSPs to be weak in areas that involve development and other business-related issues because they are monitoring the financial side of the contract

Table 14. Top three TTA requests for COSP organizational capacity.

Organization Type	*1*	*2*	*3*
COSP	*Transportation*	*Grant Writing*	*Quarterly Reporting*
	Computer Issues	*Financial Management*	*Applying for Grants*
	Developing partnership with DARS; maintaining current DSHS funding	–	–
	Transportation	*Public Awareness*	*Fundraising*
	Transportation	*Policy Development*	*Using information and data to tell your organization's story*
	Grant Writing	*Public Awareness*	*Fundraising*
	Grant Writing	*Fundraising*	*Volunteer Developement*
LMHA	*Business Management*	*Fundraising*	*Obtaining 501(c)(3) status*
	Financial Management	*Policy Development*	*Board Development*
	Grant Writing	*Transportation*	*Increasing Membership*
	Fundraising	*Grant Writing*	*Business Management*
	Volunteer Development	*Increasing Membership*	*Business Management*
	Grant Writing	*Strategic Planning*	*Fundraising*
	–	–	–

Training and Technical Assistance Content Areas for COSP

To provide effective services to consumers, staff often benefit from TTA in specific content areas. All organizations were asked to identify content areas that the COSP staff would benefit from receiving TTA. Table 15 summarizes the content areas that were selected (in frequencies and percentages). Respondents were also asked to identify the top three content areas, of those selected, in which COSP staff would *most* benefit from receiving TTA. These responses are presented in Table 16.

The content areas that were selected most frequently by the twelve organizations for COSP staff to receive were integrating behavioral and physical health, consumer-professional partnerships, and employment. Not only were these three content areas the most frequently selected, they were also perceived as being the most beneficial for COSP staff to receive TTA, in addition to WRAP and policy training (illustrated in Table 16).

The top content area, in terms of being selected by the most organizations (COSPs and LMHAs) and selected the most frequently by organizations as being the most beneficial for COSP staff to receive, was integrating behavioral and physical health. According to a report published by the National Association of State Mental Health Program Directors (NASMHPD), individual receiving services from the public mental health system in the United States die, on average, 25 years earlier than the general population (Parks, Svendsen, Singer, & Foti, 2006).

Table 15. Content Areas for COSP Staff

Content Area	*TTA Requested (frequencies and percentages)*		
	COSP	*LMHA*	*Total*
Integrating Behavioral and Physical Health (e.g. understanding the relationship, effective integration models)	***5 (9.4%)***	***5 (11.6%)***	*10 (10.4%)*
Consumer – Professional Partnerships (e.g. how to partner effectively, relationship building)	***5 (9.4%)***	***5 (11.6%)***	*10 (10.4%)*
Employment (e.g. skills for employment, maintaining employment and dealing with job loss, employment programs)	***5 (9.4%)***	***4 (9.3%)***	*9 (9.4%)*
Recovery and Resilience (e.g. basic concepts, skills, managing illness)	*4 (7.5%)*	*3 (7.0%)*	*7 (7.3%)*
Partnering in Decision Making (e.g. in individual treatment, in the public and private mental health system)	*3 (5.7%)*	***4 (9.3%)***	*7 (7.3%)*
Wellness and Recovery Action Planning (WRAP)	*4 (7.5%)*	*3 (7.0%)*	*7 (7.3%)*
Criminal Justice System (e.g. rights and responsibilities, mental health laws and the criminal justice system, options within the legal system)	*4 (7.5%)*	*3 (7.0%)*	*7 (7.3%)*
Housing (e.g. housing options, programs available to maintain housing, accessing housing information)	*4 (7.5%)*	*2 (4.7%)*	*6 (6.3%)*
Policy Training (e.g. understanding the process, developing skills for involvement in the process, developing standards for the mental health system)	*2 (3.8%)*	***4 (9.3%)***	*6 (6.3%)*
Planning for the Future (e.g. education, career, support networks, crisis prevention and management)	*2 (3.8%)*	*3 (7.0%)*	*5 (5.2%)*
System and Practice Evaluation (e.g. what it is, developing evaluation skills)	*3 (5.7%)*	*2 (4.7%)*	*5 (5.2%)*
Reducing Stigma (e.g. effective storytelling, developing and disseminating information, dispelling myths)	*2 (3.8%)*	*2 (4.7%)*	*4 (4.2%)*
Life Skills, Wellness and Prevention across the Lifespan	*3 (5.7%)*	*1 (2.3%)*	*4 (4.2%)*
Trauma in Behavioral Health (e.g. current research and findings, Post Traumatic Stress Disorder and Traumatic Brain Injury, treatment options and issues)	*3 (5.7%)*	*1 (2.3%)*	*4 (4.2%)*
Consumer/Family Advocacy Skill Development (e.g. rights and responsibilities, navigating and accessing systems, advocating for self and others, developing advocacy networks)	*3 (5.7%)*	*1 (2.3%)*	*4 (4.2%)*
Other	*1 (1.9%)*	*–*	*1 (1.0%)*
Total number of requests for assistance	***53 (100%)***	***43 (100%)***	***96 (100%)***

**NOTE: The 3 requests with the highest percentage of responses from the COSP and LMHA are in bold.*

Table 16. Most beneficial TTA content areas for COSP staff

Organization Type	1	2	3
7 COSPs	–	–	–
	Consumer-Professional Partnerships	Housing	WRAP
	WRAP	Planning for the Future	Employment
	Consumer-Professional Partnerships	Policy Training	Partnering in Decision Making
	Policy Training	Trauma in Behavioral Health	Planning for the Future
	Integrating Behavioral and Physical Health	Housing	Recovery and Resilience
	Recovery and Resilience	Reducing Stigma	Integrating Behavioral and Physical Health
7 LMHAs	Employment	Integrating Behavioral and Physical Health	Consumer/Family Advocacy Skill Development
	WRAP	Consumer-Professional Partnerships	Policy Training
	Policy Training	Integrating Behavioral and Physical Health	Employment
	Recovery and Resilience	Consumer-Professional Partnerships	Life Skills, Wellness, and Prevention across the Lifespan
	Integrating Behavioral and Physical Health	WRAP	Consumer-Professional Partnerships
	Integrating Behavioral and Physical Health	Employment	Criminal Justice System
	–	–	–

Specifically, increased morbidity and mortality rates are primarily the result of preventable medical conditions (i.e., metabolic disorders, cardiovascular disease, and diabetes) caused by modifiable risk factors (i.e. smoking, substance abuse, obesity, inadequate access to health care) as well as the use of psychotropic medications. By integrating behavioral and physical health throughout their array of services, COSPs may help extend the lifespan of this population. Peer providers may represent a particularly effective agent in bringing about these changes as they have also had to overcome these risk factors. Teaching others about the interconnectedness of behavioral and physical health may also further their own recovery. The integration of behavioral and physical health is included as a component in the Via Hope Peer Specialist Training. Similarly, the Michigan Peer Support Specialist Program focuses on assisting peers with wellness and physical health as a service type and may helpful to examine.

Consumer-professional partnerships were also frequently selected by respondents and thought to be an area beneficial for COSP staff to receive TTA. Holter and colleagues (2004) found that individuals asked to identify critical ingredients of consumer-operated programs typically highlighted components related to consumerism such as consumer control, choices, decision-making, voluntary participation, and respect by staff. TTA should emphasize the role of the individual in his/her recovery process and, at the same time, stress the importance of professional input. Both the consumer and the professional should be involved in the recovery process as each provides a unique perspective. Furthermore, consumer providers frequently advocate on behalf of the consumer within treatment teams, which may facilitate communication between

consumers and mental health professionals. Therefore, COSP staff may benefit from TTA in effectively enhancing the relationship between consumers and professionals.

Employment was also selected by many organizations and was rated as a beneficial area for COSP staff to receive TTA. Consumers commonly receive supplemental security income (SSI), social security disability insurance (SSDI), and/or other disability related insurance. As a result, they are frequently unemployed for fear of losing these benefits. Because COSPs often play the vital role of integrating consumers back into the community, they are important components in assisting individuals in developing vocational skills as well as finding and maintaining employment. Although the COSP respondents frequently identified their role in supportive employment, they were not as likely as the LMHA respondents to identify employment as being a content area important for COSP staff to receive assistance in. It may be that COSPs feel confident in their staff's ability to provide employment assistance and, therefore, do not need TTA in this area.

WRAP and policy training were also areas that were identified as beneficial for COSP staff to receive TTA, although they were not necessarily frequently selected by respondents. WRAP aims to teach participants to identify personal wellness strategies, external triggers, early warning signs that indicate potential worsening of a situation in addition to Wellness Tools that will enable the participant to move forward in the recovery process (Copeland, 1995-2009). Similar to the integration of behavioral and physical health, COSP staff can empathize with what the consumer is going through and may, therefore, be effective WRAP facilitators compared to non-peer staff. In terms of policy training, COSPs are generally structured informally and may lack the formal policies and procedures that the more formal LMHAs possess. Thus, it may be useful for COSP staff to receive TTA in developing policies and procedures that will assist them in becoming more organizationally sound.

Training and Technical Assistance Content Areas for LMHA

Because LMHA staff also provides services to consumers, they might also benefit from TTA in specific content areas. All organizations were asked to identify content areas that the LMHA staff would benefit from receiving TTA. Table 17 summarizes the content areas that were selected (in frequencies and percentages) for LMHA staff to receive. Of those selected, respondents were also asked to identify the top three subject matter areas in which LMHA staff would *most* benefit from receiving TTA (see Table 18 for the content areas selected).

Table 17. Content Areas for LMHA Staff

Content Area	*TTA Requested (frequencies and percentages)*		
	COSP	*LMHA*	*Total*
Consumer – Professional Partnerships (e.g. how to partner effectively, relationship building)	***5 (10.6%)***	***4 (10.5%)***	*9 (10.6%)*
Wellness and Recovery Action Planning (WRAP)	***5 (10.6%)***	***4 (10.5%)***	*9 (10.6%)*
Reducing Stigma (e.g. effective storytelling, developing and disseminating information, dispelling myths)	***4 (8.5%)***	***4 (10.5%)***	*8 (9.4%)*
Employment (e.g. skills for employment, maintaining employment and dealing with job loss, employment programs)	***4 (8.5%)***	*3 (7.9%)*	*7 (8.2%)*
Recovery and Resilience (e.g. basic concepts, skills, managing illness)	*3 (6.4%)*	***4 (10.5%)***	*7 (8.2%)*
Life Skills, Wellness and Prevention across the Lifespan	***4 (8.5%)***	*3 (7.9%)*	*7 (8.2%)*
Partnering in Decision Making (e.g. in individual treatment, in the public and private mental health system)	*3 (6.4%)*	*3 (7.9%)*	*6 (7.1%)*
Trauma in Behavioral Health (e.g. current research and findings, Post Traumatic Stress Disorder and Traumatic Brain Injury, treatment options and issues)	*3 (6.4%)*	*3 (7.9%)*	*6 (7.1%)*
Consumer/Family Advocacy Skill Development (e.g. rights and responsibilities, navigating and accessing systems, advocating for self and others, developing advocacy networks)	***4 (8.5%)***	*2 (5.3%)*	*6 (7.1%)*
Integrating Behavioral and Physical Health (e.g. understanding the relationship, effective integration models)	*3 (6.4%)*	*2 (5.3%)*	*5 (5.9%)*
Planning for the Future (e.g. education, career, support networks, crisis prevention and management)	*3 (6.4%)*	*2 (5.3%)*	*5 (5.9%)*
Criminal Justice System (e.g. rights and responsibilities, mental health laws and the criminal justice system, options within the legal system)	*2 (4.3%)*	*1 (2.6%)*	*3 (3.5%)*
Housing (e.g. housing options, programs available to maintain housing, accessing housing information)	*2 (4.3%)*	*1 (2.6%)*	*3 (3.5%)*
Policy Training (e.g. understanding the process, developing skills for involvement in the process, developing standards for the mental health system)	*2 (4.3%)*	*1 (2.6%)*	*2 (2.6%)*
System and Practice Evaluation (e.g. what it is, developing evaluation skills)	*2 (4.3%)*	*1 (2.6%)*	*2 (2.6%)*
Other	–	–	–
Total number of requests for assistance	***47 (100%)***	***38 (100%)***	***85 (100%)***

**NOTE: The 3 requests with the highest percentage of responses from the COSP and LMHA are in bold.*

Consumer professional-partnerships, WRAP, and reducing stigma were identified most frequently for LMHA staff to receive by all organizations (COSPs and LMHAs). In order for LMHAs to become more recovery-oriented, the consumer and mental health professional should be treated as partners in the recovery process. Although consumer providers may help facilitate communication between consumers and professionals, it is ultimately up to the consumer and the professional to develop and strengthen their relationship with one another. Therefore, TTA may help the LMHA staff (e.g. the professional) integrate consumers into the treatment process. Both

consumer providers and professional mental health providers may become WRAP facilitators and assist consumers in developing a WRAP. Research suggests that WRAP enhances the hopefulness for personal recovery, awareness of triggers and early warning signs, use of wellness tools, social support, and accountability for managing one's illness (Cook et al., 2010). LMHA staff may benefit from receiving TTA in WRAP, which would in turn benefit mental health consumers. Lastly, LMHA staff may benefit from receiving TTA in the area of stigma reduction. A significant amount of stigma is placed on individuals with a mental illness even when they seek treatment; mental health professionals should try and counter this stigma by recognizing mental health consumers as instrumental in the recovery process and consumer providers' as co-workers, who have a considerate amount of experiential knowledge (Jacobson & Curtis, 2000).

There were a variety of areas which respondents identified as *most* beneficial for LMHA staff to receive TTA. These areas were employment, consumer-professional partnerships, WRAP, reducing stigma, recovery and resilience, partnering in decision making, and integrating behavioral and physical health. The TTA needs may differ between the LMHAs, based on the fact that they may have different organizational structures, recovery-oriented service provision, geographical location, amongst other variables. Therefore, it may be necessary to take a more individually-tailored approach in the provision of TTA for the LMHAs. Of course, the COSPs all have unique needs, as well; however, there are certain TTA content areas that may be important for all COSPs to receive.

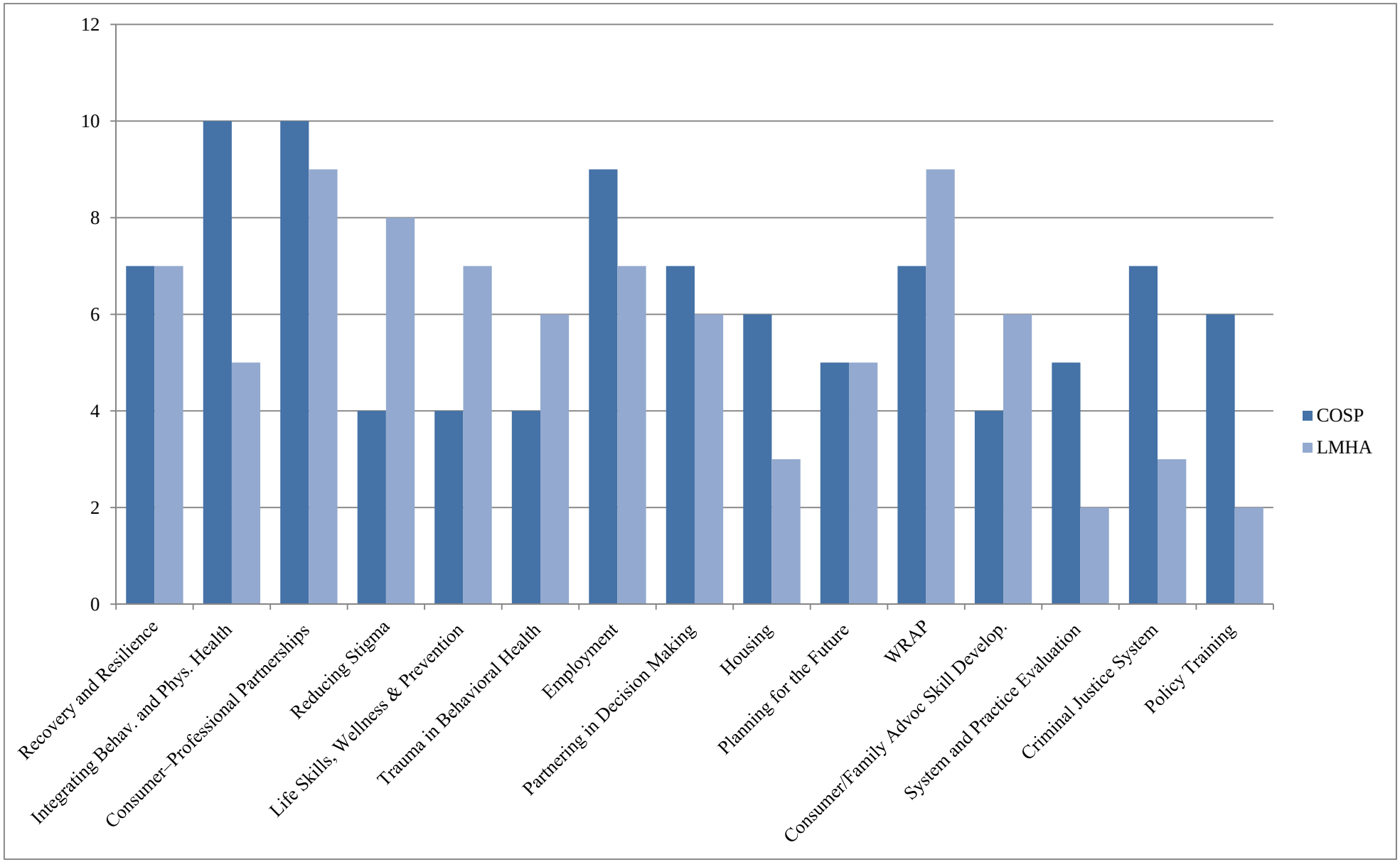
Table 18. Most beneficial TTA content areas for LMHA staff.

Organization Type	*1*	*2*	*3*
COSP	*Consumer-Professional Partnerships*	*WRAP*	*Partnering in Decision Making*
	Consumer-Professional Partnerships	*Reducing Stigma*	*Partnering in Decision Making*
	Planning for the Future	*Employment*	*Integrating Behavioral and Physical Health*
	Understanding that recovery is possible	*Reducing Staff Burnout*	–
	Reducing Stigma	*Employment*	*Planning for the Future*
	Integrating Behavioral and Physical Health	*Housing*	*Recovery and Resilience*
	Recovery and Resilience	*Consumer-Professional Partnerships*	*Reducing Stigma*
LMHA	*Employment*	*WRAP*	*Recovery and Resilience*
	Consumer-Professional Partnerships	*Partnering in Decision Making*	*WRAP*
	Employment	*Reducing Stigma*	*Trauma in Behavioral Health*
	Integrating Behavioral and Physical Health	*Recovery and Resilience*	*Employment*
	WRAP	*Consumer/Family Advocacy Skill Development*	–
	Recovery and Resilience	*Integrating Behavioral and Physical Health*	*Partnering in Decision Making*
	–	–	–

Comparison of TTA Needs for COSP and LMHA

There were a total of 96 requests for TTA for the COSP staff, compared to 85 TTA requests for the LMHA staff. Both COSP and LMHA respondents identified a higher number of TTA needs for COSPs than LMHAs. The frequencies of the TTA requested for COSP staff and LMHA staff is displayed in Figure 2 by content area. COSP staff is at least twice as likely as LMHA staff to have been identified as needing TTA in the following subject matter areas: integrating behavioral and physical health, housing, system and practice evaluation, criminal justice system, and policy training. On the other hand, LMHA staff is at least twice as likely as COSP staff to have been identified as needing TTA in only one area, reducing stigma. One explanation may be the lack of training opportunities for COSP. LMHA staff is frequently provided with training opportunities through their organization, the state or professional meetings. Because of funding, COSPs may be unable to provide training for its staff or the ability to attend meetings. Therefore, TTA should focus primarily on the needs of COSP staff, as they have a higher number of TTA needs combined with a lower number of training opportunities made available to them.

Figure 2. Comparison of TTA content areas for COSP and LMHA staff.



LMHA Training Opportunities for COSP Staff

LMHA respondents were asked if trainings provided to LMHA staff were open for COSP staff to attend. Only one organization reported that the COSP staff was not invited to attend LMHA staff trainings. Three organizations said COSP staff was sometimes invited to attend and three LMHAs said COSP staff was invited to attend. The organization that reported COSP staff is not invited to attend explained that most trainings offered by the LMHA are in specialized areas, such as RDM. This organization seems to be willing to invite COSP staff if the training pertained to their area of expertise, but so far that has not occurred. Interestingly, one of the organizations that reported sometimes inviting COSP staff to trainings clarified that the only training that included both organization's staff was on RDM. They also stated they are not opposed to including COSP in more training opportunities, they just have not done so. Those responding sometimes mentioned inviting the COSP Executive Director (one of whom is employed part-time at the LMHA) to most training opportunities, but need be more open to inviting other COSP staff. Those organizations reporting offering training opportunities to COSP staff generally let them know through the COSP Executive Director. It appears the LMHAs might not have always thought to include the COSP when there are training opportunities, but are open to doing so.

Methods for Receiving Training and Technical Assistance

All respondents were asked to select the methods they would prefer to participate in, if they were to receive TTA. These responses are summarized in Table 19 by organization type. The TTA most preferred methods were in person, conference or meeting with multiple organizations and in person, your organization only. All respondents seem to prefer in-person delivery methods. In order to enhance engagement amongst participants, those providing TTA should utilize the methods preferred by the respondents. For instance, a conference could be used to provide TTA that is applicable to all organizations in addition to giving the organizations a chance to network with one another. More tailored TTA could be provided at the individual organizations.

Table 19. Preferred methods for receiving TTA by organization type.

TTA Method	*COSP*	*LMHA*
In person, one-to-one	*1*	*2*
In person, your organization only	***3***	***4***
In person, conference or meeting with multiple organizations	***6***	***4***
One-to-one teleconferencing	*2*	*2*
Information sent through postal mail	*–*	*1*
Webconferencing that can be viewed by one or two persons via personal computer	***3***	*1*
Webconferencing that can be viewed by large groups	***3***	*2*
Online individual training	*2*	*1*
Online interactive training	*2*	***3***
Online topical chat rooms	*1*	*–*
Online topical blogs	*1*	*–*
Other	*–*	*–*

**NOTE: The top 3 choices are indicated in bold.*

Access to Teleconferencing and Webconferencing

Most (*n*=10) of the organizations reported having access to teleconferencing and webconferencing that would accommodate large groups. Of the COSPs, three reported not having access to these technologies, but follow-up questioning revealed that two of these do actually have access. One said they could take staff to the LMHA and use their equipment; the other said they have equipment, it is just not currently set up. One COSP does not have access due to cost barriers. The LMHA that reported not having access does have access to webconferencing but not teleconferencing.

Sustainability

Confidence Level Related to Long Term Sustainability of Organization

The COSPs were asked to rate their confidence level related to the long term sustainability of their organization on a 5-point Likert scale with 1 being not at all confident and 5 being extremely confident. No organization reported the two extremes: not at all confident and extremely confident. One organization reported being slightly confident, four reported somewhat confident, and two reported moderately confident. Most of the organizations (85.7%) were at least somewhat confident with the long term sustainability of their agency. When asked to explain their responses, the organization reporting being slightly confident clarified that although they are receiving new contracts, there is a need to improve in managing their funds. The four organizations reporting being somewhat confident emphasized the need for empirical research to assess effectiveness of COSPs, lack of funding opportunities that address individual needs of their organization, and lack of flexibility in grants requirements. Two mentioned that their associated LMHA recognizes the benefits of their services. One organization that is moderately confident explained that they will be able to continue providing services in some capacity because their services are beneficial. The other COSP reporting being moderately confident said they can continue providing services as long as they continue to receive money from DSHS.

Competitive Application for Funding

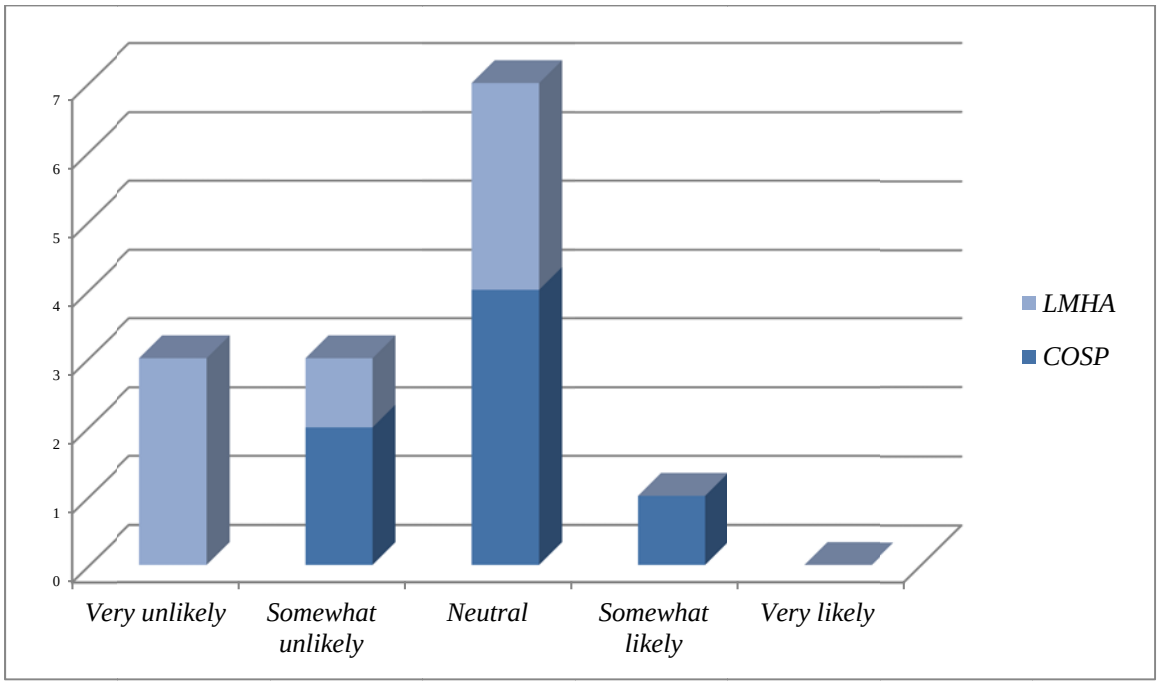
LMHAs were asked if they felt the COSP they contract with would be prepared to complete an application for funding if it was competitive. Only one organization reported that the COSP they contract with would not be prepared to complete a competitive application for funding due to the lack of writing experience. The other six organizations cited reasons for their associated COSP being prepared as a) completion of funding opportunities in the past, b) having obtained non-profit status and c) having trained employees. Further, most LMHAs indicated that they would provide assistance to the COSP in completing an application, if necessary.

Ability to Replace Lost Funding

All respondents were asked about the likelihood that the COSP (or COSP they contract with) would be able to obtain funds from other sources if funding was lost. Organizations were asked

to respond on a 5-point Likert scale with 1 being very unlikely and 5 being very likely. Figure 3 displays the responses to this question by organization type.

Figure 3. Ability of COSP to replace lost funding.



No organizations selected very likely. COSP respondents (as represented by the darker blue color) were more confident in their ability to obtain funds from additional sources if they lost funding compared to the LMHAs confidence in the COSPs ability to obtain lost funds. Three LMHAs reported it being very unlikely because of the current economy; all three mentioned the lack of financial support from sources other than the DSHS contract. Two COSPs and one LMHA reported it being somewhat likely that they could obtain funds to replace lost funding. The LMHA explained that they have demonstrated this capacity. However, they do not want to change who they are as an organization and the services they provide simply to obtain funding; rather, they want to obtain funding that fits into their organization as it is. One COSP clarified their response by emphasizing the need to contract with DARS to help with long term funding, while following up that it would be unlikely their needs would be met. The other COSP reporting somewhat unlikely said their organization is currently building a discretional fund to protect against lost funding, but it would take approximately four years to build. Half the organizations (n=7) selected neutral, four of which were COSPs and three LMHAs. The LMHAs expressed a great degree of uncertainty, with one responding "I don't know" and another stating that they are unsure who the COSP currently receives additional funding from. The other LMHA who reported being neutral, said the COSP has had some success in obtaining small funding opportunities, but do not have the level of support or infrastructure to be able to apply for competitive funding compared to other local organizations. Of the COSPs responding neutral,

explanations varied. Two expressed a need to develop a system to acquire funds. One emphasized the need to conduct empirical research on COSP effectiveness in order to replace loss. One said they were unsure they could replace operational funds. Lastly, one COSP stated it was somewhat likely they could replace lost funds because they have other funding streams through training they offer and newsletters they print.

Sustainability Plan

The COSPs were asked if they have a plan in place to continue providing services if funds were reduced. Two of the COSPs said they do have a plan, citing staff would have to go from paid to volunteer positions. Although both organizations do have a short-term plan, the period of time in which staff would be able to afford working without pay is unknown. One organization reporting that they do not have a plan to continue providing services clarified that they are unsure of what would happen short-term, but long-term they will have a discretionary fund in place. Another organization said they do not have a plan in place, but did explain that the training they provide is in demand across the world and they receive funds from DARS to train trainers. This organization also mentioned becoming a technical assistance center in the future. The other two organizations have not been able to develop a plan due to time constraints and uncertainty about the future.

Training and Technical Assistance for Better Integration

All organizations were asked what training and technical assistance would help the COSP and LMHA achieve better integration of the individual services each organization provides. COSPs mentioned communication skills, a better understanding by the LMHA of what the COSP does, more integration with other community entities, and a formalized referral process. LMHAs reported assistance with examining different funding streams, formalization of the organization, relationship building, and the employment of peer specialists.

Training and Technical Assistance for Marketing COSP Services

The COSPs were asked what TTA could assist the COSPs in marketing their services more broadly. Three organizations stated the demand for services currently outweighs what they are able to provide and, therefore, they would not want to market their services more broadly. Other organizations mentioned things like developing a website, learning to fill out applications to DARS, reducing stigma, and training on recovery and GED/education services as well as training on professional counseling and psychotherapy groups for the LPC on staff.

Business Experience of COSP Director

The COSP Directors come from a wide variety of backgrounds. When asked what business experience they possess, some reported owning small businesses, working in administrative, management, accounting and CEO positions, working as a pastor, trainer, head teller at a bank, closer at a title company and a vet technician, working in construction. One even mentioned

working abroad in the financial sector. Three mentioned their experience working as Director of the COSP (two have 10 years of experience; one has 1 year of experience).

Board's Assistance in Sustainability Planning

The COSPs were asked if their board helps them think about sustainability planning. One COSP does not have a board. Five of the organizations reported that their board does help them think about sustainability planning by planning fundraisers, talking about sustainability at board meetings, planning for the future with a non-profit consultant, offering different perspectives, and working on a project with DARS. One organization is currently looking to recruit new board members who have experience in fundraising. One mentioned that a lot of the pressure in terms of sustainability is placed on the Executive Directors shoulders. The one organization that reporting having a board that does not help think about sustainability planning said only about half of their board members are effective and they are hoping to recruit additional board members with skills to meet their needs.

Importance of Factors Related to Sustainability

The COSPs were asked to rate nine different factors that may affect the sustainability of their organization in terms of importance on a five-point Likert scale with 1 being not at all important and 5 being very important. These results are summarized in Table 20 below.

Table 20. Importance of COSP Sustainability Factors.

Sustainability Factor	*Not at all important*	*Slightly important*	*Somewhat important*	*Moderately important*	*Very important*
partnering with local, state or federal governments			*14.3%*	*14.3%*	*71.4%*
applying for grants or contracts				*28.6%*	*71.4%*
marketing services to other service providers			*14.3%*		*85.7%*
understanding reimbursement processes from funders		*14.3%*	*14.3%*		*71.4%*
managing budgets and contracts		*14.3%*	*14.3%*		*71.4%*
maintaining staffing and volunteers			*14.3%*	*14.3%*	*71.4%*
collaborating with local partners				*14.3%*	*85.7%*
receiving training and technical assistance to improve organizational capacity building		*14.3%*	*14.3%*	*14.3%*	*57.1%*
receiving training and technical assistance to increase staff competency to provide services			*14.3%*	*14.3%*	*71.4%*

None of the factors were rated at not at all important; in fact, more than half (at least four) of the organizations felt that every factor was very important. Collaborating with local partners and marketing services to other service providers seem to be the most important factors affecting sustainability of these organizations. Factors that are *relatively* less important are understanding reimbursement funding from funders, managing budgets and contracts, and receiving training and technical assistance to improve organizational capacity building.

Recommendations for Sustainability and Expansion

Improving Services

When asked what they would want the Department of State Health Services and Via Hope to know about needs that, if met, would improve service to consumers in the community, all but one organization had a response.

Responses from COSPs were mixed and needs to be addressed included: funding, instilling hope for recovery in consumers, continuing unique services for that geographical region, conducting research on cost-effectiveness, and standardizing COSP service outcomes as well as documenting outcomes through empirical studies. One COSP respondent reported that even with all of the TTA received, she felt "stretched thin," potentially indicating that more personnel are needed to sustain/expand services.

Responses from LMHAs revealed that: they were generally pleased with their relationships with the COSPs and highlighted needs to help to sustain these relationships. Recommendations called for increased integration between the organizations through incorporation of consumer providers that will eventually become certified peer specialists with the LMHA, an increased budget for funding the COSP, and expansion of COSP services to rural communities served by the LMHA.

COSP-LMHA Relationships

Another question asked both COSPs and LMHAs whether there was anything about the inter-organizational relationship that they would change. Only two of seven COSPs indicated that they would change something about their relationship. One reported a need to improve the LMHA's attitude toward having consumers as a part of its team. In other words, the LMHA should realize consumer-providers are a vital part of the recovery process. The second reported a need to increase referrals from the LMHA. Finally, although it was not explicitly stated as a need for changing the relationship, one COSP did recognize that services could be integrated more efficiently.

Three out of seven LMHAs said that they would change some aspect of the relationship. One stated that it would be helpful to increase integration with and referrals to the COSP. Another also cited increasing integration as a main concern. Finally, one LMHA said that they would like to see the membership of the COSP increased by becoming partners in community

awareness/education programs and involving COSP staff in their new employee orientation curriculum as well as provide COSP staff with training/skills to handle the increased membership. One of the LMHAs that said it would not change anything regarding the inter-organizational relationship reported that the organizations are working so well together because of an improvement in COSP programming and an increase in the number of referrals made to the COSP.

Final Comments

When asked for any final comments, all seven COSPs responded. Overall, COSPs expressed a desire to increase funding for services and research, increase legislative awareness, focus and improve the quality of services, and garner greater support from auxiliary organizations.

When asked for final comments, only three out of seven LMHAs gave final statements. One indicated that the associated COSP was open to any and all suggestions toward the need for greater integration. Another recognized consumer-providers as being a vital community resource, especially in underserved areas because of the Spanish-speaking services offered. Finally, one LMHA indicated that there have been a number of other similar groups over the years that did not survive, but the current COSP has persisted because of dedicated administration that, if lost, would jeopardize the consumer-operated nature of the services.

III. Summary of Findings

The aims of the current needs assessment were to gain an understanding of the seven existing COSP-LMHA models in the state of Texas (see map in Section I); identify training and technical assistance needs that would assist COSPs in developing the organizational capacity to become more self-sustaining; and determine how COSPs could be expanded and sustained throughout the state. This section presents a summary of the findings that may serve as a guide to next steps in achieving COSP sustainability and expansion throughout the state.

One common theme that emerged throughout all responses and explanations, regardless of organization type and level of integration, was the notion that although these organizations partner with one another, they are separate and independent entities. While most (if not all) organizations understand the importance of collaboration between traditional and peer-run mental health services, they also value the unique contributions of each organization type and strive to maintain their distinct identities, values, and roles in the mental health system.

Complementary Missions, Independent Organizations

The COSPs and LMHAs are targeting the same population and are working towards similar goals (Hodges & Hardiman, 2006) but they are utilize different methods to achieve these goals and these distinct methods are reflected in their mission statements (see Table 2). While LMHA mission statements tended to highlight the provision of services, programs and enhancing the lives of individuals with mental illnesses, the COSP mission statements emphasized themes of recovery, empowerment, advocacy, education, and community.

- LMHA staff generally rely on their education and professional expertise in the mental health domain and provide services such as case management, medication management, counseling, and vocational rehabilitation. COSPs focus less on the diagnosis and more on social/peer support and integration into the community through the facilitation of peer support groups, recreation/socialization activities, teaching self-advocacy and accessing available resources. Some of these activities may fall under the scope of vocational rehabilitation services.
- Although better "integration" of the two organizations to serve consumer needs was mentioned by most COSPs and LMHAs during the assessment, this was not defined by a merging of the two organizations but rather bringing the two independent groups into unrestricted and equal association with each other. The COSPs in particular, stressed the importance of maintaining independence. Therefore, the models should strive to enhance organizational collaboration, rather than integration.

Role of the COSP in the Public Mental Health System

The COSPs and LMHAs were asked what they thought the role of a consumer operated service provider should be in the public mental health system. In this current assessment, the goal and/or mission of the organization were operationalized using three questions: the mission statement,

organization type (of the COSPs), and the role of the COSPs in the public mental health system. Taken together, findings suggest that because these two types of organizations express distinct mission statements and envision the COSPs playing differing roles from the LMHAs in the public mental health system their goals are not contradictory but are in fact, highly synergistic. These differences demonstrate the role of the COSP in the public mental health system is critical, but may need to be more clearly defined to be better understood and utilized to their full potential.

- Some descriptions of the COSP role in the public mental health system (Table 4):
  - Offer an additional level of support and empathy, either through peer support groups or one-on-one support.
  - Act as advocates for individuals currently using mental health services.
  - Alleviate some of the pressure on the overburdened mental health system by providing additional services that the LMHAs cannot or are not currently providing, offering services to individuals on LMHA waitlists, as well as accepting individuals who do not qualify to receive services from the LMHA.

Best Descriptor of the Consumer Provider Organization

The COSPs were asked to select from a list of terms drawn from the literature the one(s) that best described their organization (see Table 3). Of 13 possible choices, respondents selected anywhere between one and nine terms to describe their organization. This variability of descriptors is corroborated by the literature, which refers to COSPs by any number of names and acronyms.

- The inconsistency of terms and acronyms highlights the need for standardization, which might help the state, consumers, mental health providers, researchers and the general population to consider these organizations a cohesive mental health service delivery entity.
- A standard, agreed upon descriptive title to describe what is referred to as a Consumer Operated Service Provider (COSP) throughout this report should also include a definition that is inclusive of the missions of these existing organizations.

COSP Operations

There was much variability among COSPs regarding their operations. Some of the COSPs were more advanced than others in areas of years of operation, budget(s), fundraising, nonprofit status, services offered, and staffing. Differences were not indicative of a lack of ability to provide services or the quality of services, but rather indicated areas where training and technical assistance and mentoring might assist in furthering sustainability.

Years of Operation: COSPs have been in operation from a range of 3 to 17 years.

Nonprofit Status: Five of seven COSPs have been incorporated as an independent 501(c)(3) entity. Of the two without nonprofit status, one has successfully partnered with another nonprofit

entity who serves as their fiscal agent, giving them opportunities typically reserved for organizations with 501(c)(3) status. The two COSPs without status have set aside funds but not yet found the time to apply.

- Some, if not all, of the COSPs would benefit from assistance in either applying for or maintaining their 501(c)(3) nonprofit status. Some COSPs who are 501(c)(3) stated that applying for and receiving status is fairly easy, the difficulty is maintaining and completing the required IRS paperwork to keep the status. Some have used funds for CPA assistance.
- Several of the COSPs were aided in applying for 501(c)(3) status with funding and other support from the Texas Mental Health Consumers. This type of ongoing support, whatever form it may take, would assist with sustainability.

Board of Directors: Six of the seven COSPs have a Board of Directors or a similar advising body. Boards were said to provide support and guidance on the future of the organization, particularly financial guidance. The boards range from 5 to 12 members and most meet on a monthly basis. The six boards are comprised of 33% to 100% consumers; making up a majority (at least 60%) at five of the six organizations. Three of six boards include family members of consumers on their board. One COSP does not have a Board of Directors or other kind of advisory board.

- Only one LMHA includes consumers (n=1) on their Board of Directors. Five LMHAs do not include consumers on their board and one is unsure of the composition of the board. However, most (n=6) of the LMHAs do include family members of consumers on their boards. Because the consumer perspective is an important aspect of the recovery process, LMHAs should strive to enhance recovery oriented practices by increasing consumer involvement on their board and other advisory committees besides the PNAC (which is required by DSHS).

Funds: COSP contracts with LMHAs ranged from $24,000 to $71,500 although five COSPs had other sources of funds, which could be considered an indicator of sustainability. Three COSPs indicated receiving other funding that ranged from $17,000 to $70,000. One COSP had a contract to provide a program they developed (Recovery 101) at the LMHA although the amount of funds was not given. Another COSP has a Hogg Policy Foundation grant which paid for the development of educational materials for a “Work and Benefits” program. Two COSPs have no other source of funding other than DSHS funds.

- Although there was a desire to assist more consumers, as expressed through a need to increase referrals from LMHAs, this was tempered by some COSPs who reported a lack of resources to serve more consumers. In other words, the demand for COSP services currently outweighs the ability to provide them. Several COSPs expressed a desire to bill for [more] services; however, billing itself would require additional requirements and skills the COSPs do not currently possess.

- Two COSPs discussed the need to build a discretionary fund for sustainability in times of uncertainty, although these funds would have to come from a source other than DSHS.
- Two of the four training and technical assistance needs identified by COSPs were grant writing and fundraising, both of which are clearly related to financial sustainability.
- In addition to funds, six of the COSPs reported receiving in-kind or other sources support in the form of office space, meeting space, gym memberships, parking, recreation donations, newsletter printing, computers, and furniture.

Payment Arrangements: The most common form of payment from funding organization to COSP is upfront monthly/quarterly payments (five COSPs), followed by reimbursement for services (three COSPs), fee-for-service (one COSP), and other - membership donations (one COSP).

- Some COSPs receive funds from more than one source and more than one payment method.
- Those COSPs receiving upfront payments were generally satisfied, with the exception of late payments. Those who are paid through monthly or quarterly reimbursement for services find this method difficult because it requires having a certain amount of money on hand available. Because these organizations operate with smaller budgets, they often do not have money reserved (re: need for a discretionary fund) and the financial burden falls on the shoulders of the Executive Director. One COSP respondent reported having to pay for certain expenses out-of-pocket and then wait to be reimbursed.

Contract Monitoring: Most organizations report that monitoring staff generally visit the COSP once a quarter to verify that operations are running smoothly, to ensure that expenditures are in place, and to gain a sense of satisfaction and effectiveness associated with the COSP.

- The LMHAs report no unresolved issues with COSPs in handling their contract. Any issues that arise are discussed between the two organizations and are addressed to the LMHAs satisfaction. The TTA suggested by the LMHAs for the COSPs does however suggest feelings that some of the COSP management practices could be improved (see TTA below and page 33 of report).

COSP Staff: Number of staff range from 3 to 27 individuals

- 5.6% of positions are full-time, 47.9% are part-time, and 46.5% are volunteer positions. The large percentage of volunteers may highlight the need for TTA in volunteer development and the establishment of a career ladder, which could alleviate high rates of turnover, provide motivation, and enhance sense of ownership of COSPs.
- Two COSPs had full-time staff: 1 with two full-time positions and 2 with one full-time position. Executive Directors are generally full-time (salary range of 15,000-24,000 a year).
- Five COSPs staff are comprised of 100% consumers; one COSP is comprised of 75% consumers; and one COSP does not currently have any consumers employed at their organization, which is highly unusual for a consumer operated organization.

- Staff salaries range from minimum wage (currently $7.25 an hour) to $24,000 a year but salaries also include flat rates, e.g. facilitating peer support groups ($60 per group).
- Three COSPs had career ladders or a semblance of a ladder in place. Career ladders also appeared to be helpful in the engagement and recovery of consumers and helped prepare them for the workforce. It may be helpful for those with career ladders to document or share their process with other COSPs in a mentoring role.
- Of six COSPs with consumer staff, three had job descriptions for staff on hand and one other was currently working on job descriptions. The need for added structure in some COSPs falls in line with some of the TTA LMHAs mentioned was needed by COSPs (e.g. volunteer, board and policy development and business management). This would assist with sustainability.

Days and Hours of Operation: All COSPs are open at least 4 days a week and all have an office at which they provide services. Two provided services one evening a week (support groups) and none were open on weekends.

- In addition to providing services at the COSP location, four also provide services at the community mental health center offices and five provide services in other community organization offices, such as in area psychiatric hospitals, private hospitals, churches, and local foundations. The provision of space by these organizations was often cited as in-kind.

Services Offered by COSPs: A review of the literature produced a list of 20 services commonly provided by COSPs. Of the 20 services listed, the seven COSPs reported providing a range of 5 to 18 services, with the average number of services provided by the organizations being approximately 12 (Table 5 and Table 6).

- Services provided most frequently by the COSPs were: one-on-one peer support, facilitating peer support groups, transportation assistance, accessing community resources, recreation/socialization, and computer/technology services.
- An operational definition of peer support in-line with current or future rules may support the ability of COSPs to bill for these services. Billing would add another level of responsibilities to the COSPs requiring the provision of TTA and perhaps technological support.
- Evaluating the effectiveness and success of services more fully could help determine which are best suited to meet consumer recovery needs (see Outcomes below).

Number of Consumer Served: The seven COSPs reported serving between 10 and 40 consumers in one day and 30 and 250 unduplicated consumers each month.

- It was more typical that consumers received more than one service from the COSP staff at a visit. Not all COSPs can document the type or amount of services each consumer received.
- A majority of COSPs recognized the importance of collecting information beyond the number served to demonstrate service effectiveness. A collective process to discuss and select reasonable measures could be helpful to the COSPs. This would require TTA to select

the most meaningful measures in the least burdensome and most cost-effective way. COSPs currently collecting this information might share their processes or serve as mentors.

- Several COSPs also mentioned the desire to participate in an outcomes study to demonstrate the value and effectiveness of the services they provide.

Communications

Referral Entities

Of three answer choices, all COSPs reported serving consumers that were referred by all of the referral choices, including the CMHC, other community entities and self-referred. This highlights the openness of these types of organizations.

- The LMHA is the most common referral entity. Other community entities that refer consumers to COSPs include adult probation, 211, Mental Health America (MHA), National Alliance of Mental Illness (NAMI), churches, universities, local foundations, the Department of Assistive and Rehabilitative Services (DARS), Goodwill, the Salvation Army, and others.

Referral Process

Neither the COSPs nor the LMHAs have a formal referral process in place. It appears that referrals are based on the relationships and communication of COSPs with specific staff at LMHAs and other organizations.

- There was variability in responses from COSPs and LMHAs when asked if there was/or should be a formal referral process. Some COSPs would like more referrals while others are satisfied with the number they receive given the resources they have. Some COSPs ask the consumer who referred them on "intake" paperwork, but not all track or store this information. LMHAs do not track the consumers they refer to the COSP and tended to report that the referral process in place works well for them and preferred not to formalize it.
- There are opportunities to better understand who receives services from COSPs, if not by formalizing a referral process, then by collecting information from consumers on who referred them to COSP services.

LMHAs, Local Entities, other COSPs, DSHS, State/National Consumer Groups

COSPs generally communicate most often with staff at the LMHA and least frequently with staff at national organizations that support consumer/family efforts, with over half the respondents never talking to these types of organizations (Table 8). COSP respondents reported a high percentage of monthly contact with DSHS staff, but this is a recent occurrence coinciding with the monthly COSP-LMHA calls held by DSHS. Only one COSP has a strong relationship with the state hospitals, as they contract peer support services to psychiatric hospitals.

- Several COSPs mentioned the role that Texas Mental Health Consumers had played in keeping them abreast of state and national news, issues, and best practices as well as keeping them connected as a group and providing TTA. Providing a mechanism (that Via Hope might

serve) to facilitate communications on these topics would assist with COSP development and sustainability, such as providing information on becoming a DARS vendor, billing Medicaid, and obtaining liability insurance for staff.

- Increased communication between the COSPs may facilitate collaboration and learning opportunities while strengthening the consumer movement. Furthermore, increased awareness of these organizations at the national, state, and local level may enhance partnership and networking opportunities.
  - One mechanism for increasing communication and awareness may be to develop a network of COSPs.

Strategies Used by COSPs to Communicate Services

The most commonly reported strategy used to communicate COSP services was word of mouth, followed by networking and websites (Table 11). However two COSPs do not currently have websites.

- All seven LMHAs stated that they do communicate COSP services to consumers through the verbal communication of individual counselors and caseworkers and through written materials such as brochures, pamphlets, or newsletters. None include a link to the COSP website on the LMHA website.
- Most referrals to the COSP are from LMHA caseworkers. Awareness of COSP services could be increased throughout all level of the organizations to increase the number of referrals and collaborative efforts.

Funding Opportunities

Six COSPs are alerted to grant or funding opportunities mainly via email and six have applied for federal, state, or local grants in the past. One organization has never applied for a grant because of time-constraints and lack of resources. The biggest barrier in applying for funding seems to be a lack of funding opportunities for consumer organizations (Table 7).

- Barriers to applying for funding were: application window too narrow/not enough notice received, inexperience at writing proposals or applications, applications are not a good fit for our organization, and other. When asked to specify "other" COSPs mentioned barriers such as wordy or confusing documentation, not having necessary documents to apply, lack of resources to write grants, lack of grants that will assist organizations in becoming financially sustainable over time (i.e., grants are a one-time, time-limited source of funding), and not wanting to modify their organization based on the grant (wanting to apply for grants that fit with the work they are already doing).

- To overcome barriers, suggestions included enhancing access through early notification for a wide variety of grants, both in terms of funding amount and topic area, and networking with other peer support groups to jointly apply. Organizations expressed an interest in a system that sends out a notification regarding all available, relevant funding opportunities for organizations like COSPs and filtering out grants not applicable to them. Also, time management and/or grant writing courses/workshops could be provided to assist with producing competitive applications.

Outcomes and Impact of COSPs in the Community

All COSPs reported that they track the number of consumers served. Most reported that they used sign-in sheets and attendance logs to track numbers. Six out of seven COSPs reported that they track the number of services provided using various methods such as intake paperwork, class attendance sheets, and telephone logs. Two of the organizations reported the use of electronic records for this purpose.

- To determine program success, two of the COSP organizations reported using quantitative methods including program attendance, increases in referrals, and number of journeymen gaining employment, three COSPs reported using both quantitative (i.e., attendance and clinical outcomes) and qualitative data (i.e., surveys, feedback, and written testimonials). Two COSPs reported using only qualitative, anecdotal methods for evaluating success including observing the attitudes of consumers and witnessing outcomes.
- COSPs measure their outcomes via satisfaction reports, services utilized, anecdotal feedback, needs self-assessments, consumer essays, and verbal communication. In measuring the success of services provided, most COSPs reported that they generally lack a way to measure the impact/worth of such services.
- Five LMHAs reported using a list of outcomes provided by DSHS as contract attachments to evaluate success in meeting contract requirements. One LMHA said that they reviewed a monthly report submitted by the COSP and one LMHA was unsure of how success in meeting contract requirements was assessed.
- LMHA contract outcomes include items such as daily census, number of peer support groups, minimum number of consumer employees, providing outreach services, etc. When asked how they knew if the COSP was successful and how they measured this success, they were mixed on whether they used objective or less formal, subjective measures. Some reported that they used only objective criteria including numbers, budgets, and contract outcomes. Others reported using anecdotal measures, progress notes, site visits, and verbal communications.

- All 14 COSPs and LMHAs thought that consumers had better outcomes when they utilized services of both types of organizations than if they had used only LMHA or COSP services. Reasons for this included aspects which were almost exclusive to COSPs such as: non-judgmental social support, individual engagement, experiential knowledge of consumer-providers, community activities, skills training, resources offered in a community setting, transportation services, and mentoring relationships and also included comments on the capacity of LMHAs to provide psychiatrists, medications, specific non-pharmacological treatments, access to housing, medical/clinical skills, and outpatient services. Generally, the organizations agreed that the model for the best consumer outcomes is collaborative.
- Overall, there are no standard measures and methods to determine outcomes of COSPs.

Peer Specialist Training

Most organizations (4 COSPs and 5 LMHAs) have staff that attended the Via Hope Peer Specialist Training. The number of staff working as peer specialists at COSPs-LMHAs ranges from 0 to 10. Some COSPs and LMHAs noted that some were certified by the Depression Bipolar Support Alliance (DBSA) or through NAMI's Peer-to-Peer Training, rather than by Via Hope. One LMHA commented that they rely on their affiliated COSP to provide peer support services, therefore they do not currently have any peer specialists working directly for their center.

- There was a high level of interest in the Via Hope Peer Specialist Training and Certification, with all seven COSPS expressing interest and most suggesting they would like staff members to apply for upcoming trainings. One organization stated they had just recently become aware of the program, indicating a need to increase awareness of the program.
- One LMHA reported that they relied on their peer specialists to provide more "therapeutic services" and looked to the COSP to provide more support type services. It would beneficial to the future development of peer support services and the peer specialist designation to explore the use of peer specialists in the two organizations to determine commonalities and differences in job descriptions and responsibilities.
- In the future service system (given health care reform or other changes toward recovery oriented systems), a common definition of peer specialists and the definitions for the variety of peer supports that could be provided (and billed for) by peer specialists will be necessary.
- If peer specialists role in the system expand, planning to support their training, technical assistance, ongoing continuation education needs and potentially their differing job functions will be needed.

Training and Technical Assistance

Based on the requests for training and technical assistance in the development of COSP organizational capacity, the COSPs feel they need the most assistance in the domain of technical capacity, whereas the LMHA perceives the need for COSP improvement in the domain of management capacity area (see below and Table 13). Content areas that were indicated as being

important were integrating behavioral and physical health, consumer-professional partnerships, employment, WRAP, and policy training (see below and Table 15). LMHA staff also often work with consumers and possibly in conjunction with COSP staff. Therefore, they may also benefit from receiving training in certain areas. Areas identified as being beneficial for LMHA staff to receive were consumer-professional partnerships, WRAP, reducing stigma, recovery and resilience, partnering in decision making, and integrating behavioral and physical health (see below and Table 17).

- Perhaps the more meaningful finding revealed in these responses is that regardless of capacity area or organization type, most areas indicated as being important for COSP development were related to issues of sustainability such as grant writing and fundraising. The organizations expressed concern over the long-term sustainability of their organization, specifically regarding the potential for DSHS contracts to be cut or reduced. Yet, few organizations have a sustainability plan in place to continue providing services if funding is reduced. Training and technical assistance should not only address how to obtain funds, but assist in developing a plan that will detail how the organization will operate if funding is lost.
- It should be noted that the needs discussed here are the overall themes that emerged from all data collected. However, each individual COSP-LMHA model likely has specific needs that could be addressed. Because the organizations are better able to identify their needs than outside entities, TTA should revolve around the self-identified needs of their organizations.
- Both COSPs and LMHAs favored in-person delivery methods for TTA (one-on-one, organization, conference) although webconferencing was acceptable to 43% of COSPs and online interactive training was acceptable to 43% of LMHAs (Table 19). One COSP does not have access to web or teleconferencing.
- Based on this feedback, it is recommended that training and technical assistance be provided in two different forums: 1) at a conference or meeting that allows the organizations to network and also to address needs that emerged; and 2) at the organization itself in a manner that is individually-tailored based on the specific needs of that organization.

TTA Needs Reported for COSPs:

- Most frequent requests for Organizational Capacity TTA by COSPs for COSPs: grant writing, fundraising, transportation, and volunteer development (see Table 12).
- Most frequent requests for Content Area TTA by COSPs for COSP staff: integrating behavioral and physical health, consumer-professional partnerships, and employment (see Table 15).
- Most frequent requests for Organizational Capacity TTA by LMHAs for COSPs: grant writing, fundraising, and business management (see Table 12).
- Most frequent requests for Content Area TTA by LMHAs for COSP staff: integrating behavioral and physical health, consumer-professional partnerships, and three topics that received the same percent of selection: employment, partnering in decision-making, and policy training (see Table 15).

TTA Needs Reported for LMHAs:

- Most frequent requests for Content Area TTA by LMHAs for LMHA staff: consumer-professional partnerships, WRAP, and recovery and resilience (see Table 17).
- Most frequent requests for Content Area TTA by COSPs for LMHA staff: consumer-professional partnerships, WRAP, and four topics that received the same percent of selection: reducing stigma, employment, life skills wellness prevention across the lifespan, and consumer/family advocacy skill development (see Table 17).

Stage of Collaboration between COSPs and LMHAs (Models):

According to the relationship framework applied by Hodges & Hardiman (2006), the collaboration between consumer-run and community mental health agencies can be categorized into one of four hierarchical stages of interaction: 1) referral, 2) coordination, 3) coalition, and 4) cooptation/joint ventures.

- The COSPs and LMHAs are primarily in the collaboration stage of Referral, although some do exhibit some degree of Coordination (that is primarily informal and not necessarily intentional).
  - All of the LMHAs reported referring consumers to COSP services and a few of the COSPs reported making referrals to the LMHA but none have a formalized referral process established with referrals being primarily relationship-based.
    - Four COSP-LMHA models are in the referral stage.
  - An important component of the coordination stage already exists between the COSPs and LMHAs, the acceptance and recognition by each organization of the legitimacy and unique contributions of the other organization's service technology (Hasenfeld & Gidron, 1994). Most organizations acknowledged the fact that consumers receiving services from both organizations typically have better outcomes than consumers who are receiving services from one organization, exclusively.
    - Three COSP-LMHA models exhibit some degree of coordination.
  - The organizations and the funding agencies should keep in mind that collaboration often happens by default, not choice (Hodges & Hardiman, 2006). Within the current mental health system in Texas, the COSPs are funded through the LMHAs. If LMHAs were not required by DSHS to fund and monitor the COSP contracts, collaboration may not be occurring at all between these two entities.
- If these COSP-LMHA models are provided training and technical assistance to build their capacity and enhance the skill set of their staff members, it is likely that integrative and collaborative efforts will increase. If a relationship develops that is both mutually beneficial and effective in terms of producing positive consumer outcomes, additional model may arise across the state. As a result, the public mental health system can progress to a truly consumer-driven, patient-centered system.

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