

SPECIAL SECTION

Cultural Competency in Peer-Run Programs: Results of a Web Survey and Implications for Future Practice



Jessica A. Jonikas

University of Illinois at Chicago

Stephen Kiosk

National Alliance on Mental Illness,
Support, Technical Assistance, and
Resources Center,
Arlington, VA

**Dennis D. Grey and
Marie M. Hamilton**

University of Illinois at Chicago

James McNulty

Depression and Bipolar Support
Alliance, Chicago, IL

Judith A. Cook

University of Illinois at Chicago

Objective: The study explored perceptions of adults with psychiatric disabilities regarding cultural competency of peer-run mental health support groups and programs. *Methods:* Web survey respondents were recruited via mental health listservs, web sites, newsletters, emails, and word of mouth. A total of 527 peers were surveyed about cultural competency barriers facing peer-run programs; common reasons for not using peer services; and strategies to engage diverse communities. *Results:* Both multicultural and Caucasian respondents agreed that lack of funding and staff education about diversity were barriers to cultural competency in peer programs. Multicultural respondents were more likely than whites to feel that both the recognition of the need for and interest in attending cultural competency training is lacking in peer programs, as well as information about the diverse composition of peer program memberships. Among those who had never participated in peer support, people of color were more likely than whites to endorse feeling they would not belong and believing their languages would not be spoken in peer programs. Whites, on the other hand, were more likely to cite a preference for professional over peer support, while nearly half of both groups indicated that the main reason for non-attendance is a lack of knowledge about peer programs. Qualitative results highlighted successful outreach and engagement strategies. *Conclusions:* Study findings informed development of a cultural competency tool that was pilot-tested among peer-run programs. Given the importance of peer support in recovery, these findings suggest the need for additional research on cultural competency in peer programs.

Keywords: peer support, cultural competence, diversity, self-help groups

ACKNOWLEDGEMENTS:

THIS PROJECT WAS FUNDED BY THE U.S. DEPARTMENT OF EDUCATION, NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH, AND THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, CENTER FOR MENTAL HEALTH SERVICES, UNDER COOPERATIVE AGREEMENT H133B050003B. THE PROJECT WAS ALSO FUNDED BY GRANT NUMBER #SM056675 (VIA THE NAMI STAR CENTER) FROM SAMHSA. THE VIEWS EXPRESSED DO NOT REFLECT THE POLICY OR POSITION OF ANY FEDERAL AGENCY.

Introduction

During the past twenty years, landmark legislation and several influential reports have promoted meaningful community participation and attainment of a fulfilling life for people with disabilities. Within this context, recovery and self-determination have increasingly been promoted as the

guiding vision for transformed mental health services and systems (Anthony, 1993; Cook & Jonikas, 2002; Davidson, Tondora & O'Connell, 2007; Deegan, 1988; Jacobson & Curtis, 2000; Onken et al., 2007). This trend is bolstered by the growing emphasis on the value of peer support and mutual self-help as both alternatives and complements to traditional services, with one study showing nearly 535,000 users of con-

sumer-operated programs in the year surveyed (Goldstrom et al., 2005). In spite of these promising developments, however, disparities continue to exist between Caucasians and people of color regarding access to and quality of mental health care (US DHHS, 2001). Additionally, although multicultural individuals use self-help services and peer support (US DHHS, Office of Applied Studies [OAS], 2009), little research has been published to date on how peer program membership feels about and manages their own and others' diversity within the context of mutual support. Therefore, this article describes a national web survey of adults with psychiatric disabilities to assess their views on cultural competency within mental health self-help groups and peer-run programs. Described are the survey, preliminary quantitative and qualitative results, survey limitations, and implications for future research and programming.

Literature Review

Mental Health Mutual Support. For many decades, people with psychiatric disabilities have come together to offer one another practical, social, and emotional support, as well as a vision of hope and recovery (Campbell, 2005; Chamberlin, Rogers & Ellison, 1995; Cook & Jonikas, 2002; Davidson et al., 1999). Peer support has been defined as giving and receiving help based on respect, shared responsibility, and mutual agreement of what is helpful (Mead, Hilton & Curtis, 2001), and is used as both a complement to and a supplement for traditional mental health services (Goldstrom et al., 2005). Consumer-operated programs, or those managed, staffed, attended, and evaluated entirely by people with psychiatric disabilities (Swarbrick, 2007; Van Tosh, Ralph & Campbell, 2000), have gained momentum through the years as an empowering

option for both the givers and receivers of care (Corrigan, 2006; Rappaport, Resichl & Zimmerman, 1992; Segal, Silverman & Temkin, 1993).

A growing body of literature addresses the positive outcomes of peer support services, both for the providers and recipients. As described by Solomon (2004), a number of studies have shown that, as a result of offering others mutual support, peer providers experience reduced reliance on psychiatric hospitalization, and increased self-esteem, confidence, empowerment, hope, and quality of life, as well as enhanced social support, productivity, and career skills. Studies also reveal many similar benefits of peer services to recipients, although findings must be interpreted with caution due to the less rigorous designs of most studies to date. Specifically, people who receive peer support are reported to have reduced psychiatric symptoms and psychiatric hospitalizations, improved social functioning, enhanced social support, recovery, hope, self-esteem, and quality of life, and less formal service utilization (Campbell, 2005; Cook, Copeland et al., 2009; Salzer & Shear, 2002).

Mental Health Treatment Disparities. Widespread disparities between multicultural groups and their white counterparts persist in mental health treatment settings. In general, people of color have less access to psychiatric services (due to factors such as lack of convenient locations; lack of insurance), are less likely to remain engaged in treatment, are more likely to suffer from improper dosing of psychiatric medications, and their psychiatric care is less likely to be based on current standards of evidence than that of their white counterparts (Atdjian & Vega, 2005; McGuire & Miranda, 2008). Moreover, it has been shown that multicultural individuals are more

likely than whites to delay or avoid seeking traditional mental health treatment (Kessler et al., 1996; Sussman, Robins & Earls, 1987; Zhang, Snowden & Sue, 1998).

There appear to be many reasons for the tendency to avoid Western treatment, including cultural variation in how psychiatric distress and help-seeking are viewed, discouragement of the sharing of personal problems outside of one's family, lack of linguistic competence in many mental health settings, and enduring lack of diversity in the mental health workforce (Cook, Razzano & Jonikas, 2009). The stigma that surrounds having a diagnosis of mental illness also can inhibit multicultural individuals' willingness to access and engage in services (U.S. DHHS, 2001). As a result, many experts have called for the development of cultural competency within behavioral health care systems, which would require providers and supporters to exhibit the knowledge, attitudes, and skills necessary to help people from many diverse backgrounds achieve recovery (Whaley & Davis, 2007). When systems become culturally responsive, services and supports will be tailored toward people's unique backgrounds, thereby facilitating access, engagement, service retention, and positive recovery outcomes across cultures (Sue & Torino, 2005).

Certainly, peer services are included in this call for cultural competency and, as demonstrated by the National Survey on Drug Use and Health, multicultural individuals who have received traditional treatment during the past year participate in mutual support groups and peer programs at rates generally greater than that of their white counterparts, with the exception of Asian Americans (US DHHS, OAS, 2009). Specifically, when considering people surveyed who received both past year traditional treatment and

past year peer support, 8.1% were black or African American, 7.9% were Hispanic/Latino, 5.1% were white, 3.8% were Asian American, and 5.6% were two or more races.

The purpose of the present study was to explore peers' perceptions of cultural competency at both the peer provider and the organizational levels within peer-run programs/groups. Perceptions of multicultural and white peers who do and do not attend peer-run programs were obtained. For this study, the definition of cultural competency was comprised of the standard components: 1) attitudes towards race, ethnicity, and culture; 2) knowledge about cultures that differ from one's own; and 3) skills to interact and communicate effectively across cultures (Whaley & Davis, 2007). At the provider level, cultural competency is demonstrated when staff (in this case, peer providers) have the attitudes, knowledge, and skills to interact comfortably and effectively with clients (in this case peer members) from a variety of cultural backgrounds. At the organizational level, cultural competency is demonstrated when programs develop a mission statement, program policies, hiring practices/staffing patterns, and services or supports that promote cultural diversity and competence among the staff and clientele. The current study also explored perceptions of the cultural diversity of peer programs, defined as whether or not people from non-majority groups were present and active in these programs.

This research was one component of a project run collaboratively by the University of Illinois at Chicago National Research and Training Center (UIC NRTC) and the Support, Technical Assistance, and Resources (STAR) Center at the National Alliance on Mental Illness. Research questions included the following. First, what com-

mon cultural competency barriers are reported by those attending peer programs/groups and do perceptions of these vary by race/ethnicity? Second, what reasons do peers have for not attending peer-run programs and do these vary by race/ethnicity? Third, what challenges and successes have peers had in promoting cultural diversity and competency within peer programs?

Methods

Sampling Strategy. A convenience sample of adults self-identifying as having had mental health problems was obtained through national outreach. Announcements in both English and Spanish were posted to a dozen mental health listservs and web sites, with special emphasis on sites operated by mental health peers and people of color. Flyers were distributed at national conferences, especially peer conferences, and the study was advertised in relevant newsletters. The authors also used their national networks of peer leaders and cultural competency experts to distribute the announcement at local/state meetings and to peer-run programs directly. The announcement explained the purpose of the survey, described eligible respondents, and provided a secure web address where people could complete the survey online with full anonymity. Contact information for the UIC NRTC was provided for people who had questions or to request a paper copy of the survey for those who did not have computer access or preferred to complete it by hand.

Sample. A total of 527 participants completed the survey. The majority ($n=328$, 62.2%) was Caucasian; 13.1% ($n=69$) were African American; 10.6% ($n=56$) Hispanic/Latino, 4.9% ($n=26$) Native American/Alaska Native; 1.5% ($n=8$) Asian/Pacific Islander; 3.6%

($n=19$) multi-racial/ethnic; and 4.0% ($n=21$) "other." At the beginning of the survey, respondents were asked to identify themselves as belonging to one of four groups: 1) racially/ethnically diverse people who had participated in peer-run groups or programs ($n=119$); 2) racially/ethnically diverse people who had never participated in peer support ($n=57$); 3) white people who had participated in peer support ($n=235$); and 4) white people who had never participated in peer support ($n=116$). While 62.2% said they were Caucasian when responding to the question about their race/ethnicity, 66.7% classified themselves as "non-minority" when responding to the four group question. This common inconsistency in self-reported ethnicity has been documented in other surveys, including the U.S. Census (McKenney & Bennett, 1994). For the remainder of this article, participants are classified according to the four group question. There were no significant differences between peer support participants and non-participants in terms of their racial or ethnic background. As shown in Table 1, respondents were primarily women, their average age was early to mid-forties, the large majority had a high school education, and most lived in urban or suburban areas. Half or more were employed, and fairly low proportions reported incomes of less than \$10,000 per year.

Web Survey Instrument. In developing the survey, common themes and features across published cultural assessments were identified (for example, Association of University Centers on Disabilities, 2004; National Center on Cultural Competence, n.d.; Siegel, Haugland & Chambers, 2004; US DHHS, HRSA, 2002). Additionally, listening sessions and individual interviews with peers at two national conferences were conducted to ascertain cultural themes unique to peer

TABLE 1—DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS

| | Racially/Ethnically Diverse | | Caucasian | |
|------------|-----------------------------|-----------------|-------------|-----------------|
| | Participant | Non-participant | Participant | Non-participant |
| N | 119 | 57 | 235 | 116 |
| Female | 68.9% | 80.7% | 73.2% | 80.2% |
| Avg Age*** | 45.7 | 40.4 | 48.8 | 40.3 |
| HS+ Educ* | 93.3% | 96.5% | 98.7% | 97.4% |
| Working | 50.4% | 59.6% | 57.8% | 54.3% |
| Urban** | 51.3% | 36.8% | 35.3% | 26.7% |
| Suburban* | 32.8% | 42.1% | 43.0% | 52.6% |
| Rural | 16.0% | 21.1% | 21.7% | 20.7% |
| <10K/Year | 24.4% | 12.3% | 16.6% | 15.5% |

***= $p < .001$, **= $p < .01$, *= $p < .05$

programs. The resulting survey was comprised of 4 sections. First was a series of check-off items for peer support attendees related to problems their programs may have faced in meeting the needs of multicultural people. Sample items included: “The program or group lacked education about the needs and beliefs of people from diverse cultures”; and “The program or group lacked translation services for people who speak different languages.” Second was a series of open-ended questions for peer support attendees to describe their own experiences with cultural competency barriers, peer program success stories in supporting diversity, awards for diversity that their program may have received, and strategies their peer programs used to engage and support diverse membership. The third survey section contained a series of check-off items describing reasons for not attending peer services, such as “Peer-run programs don’t respect my race, ethnicity, or culture” or “I don’t know of any peer-run programs or groups.” The survey concluded with a set of demographic questions for all respondents.

Web Survey Procedures. The instrument was written at the 7th grade reading level to be inclusive of individuals with lower literacy. Programming involved automated skip patterns, immediate range and error checks, forced responses to applicable items, a series of open-ended items, and respondent-generated data submission. The survey was available to anyone with Internet access (or to those who requested paper copies from the UIC NRTC). Upon visiting the survey web site, peers were provided with the choice of completing the survey in English or Spanish. They were then taken to an overview of the survey and instructions for completion. The survey began with a set of questions for respondents to identify whether or not they had mental health problems, were white or a person of color, and had ever attended mental health self-help or a peer-run program. Skip patterns then led them to a set of survey questions that took 10 to 20 minutes to complete. At the end, respondents were thanked for their time and encouraged to pass the web survey address on to a peer. The web site and secure database were hosted by Vovici, and all transmitted data were encoded using Secure Sockets Layer

encryption. Neither Internet Protocol (IP) addresses linked to the device used to complete the survey nor any other identifying information about the respondents was collected. The survey was posted from January 2008 to April 2009. All research procedures were approved by the UIC Institutional Review Board.

Use of a Web-Based Format. Careful consideration was given to the best format for a survey of diversity and cultural competency (a sensitive topic for many reasons) among self-help and peer programs nationally. Although a detailed discussion of the advantages and disadvantages of interactive web-based surveying is beyond the scope of this paper, some of the benefits of a web format include: broader and more affordable national access to survey respondents; the documented ability to engage difficult-to-reach participants with computer-mediated surveys, especially those who do not wish to identify themselves or their disability to researchers (Braithwaite, Waldron & Finn, 1999; Cook et al., 2007); ability to ensure strict anonymity, especially when addressing a highly sensitive topic; reduced pressure on respondents to provide socially desirable answers; and the ease and accuracy of automated data collection (Wright, 2005). Some of the drawbacks to the web format include: concerns about representativeness of and self-selection bias in the sample; and the validity and accuracy of the data collected. Since these same drawbacks can be present in mail and in-person surveys (Wright, 2005), a web-based format was chosen for the present study.

Data Analysis

Frequency distributions and descriptive statistics were computed for all study variables. Chi-square analysis was used to determine associations between respondents’ minority status

and different reasons for not attending peer programs, and perceptions of multicultural barriers in peer programs. In addition, respondents were asked to describe in their own words their reasons for not attending peer-run programs, and barriers to cultural competency in these programs. These written responses were analyzed using the method of Constant Comparative Analysis (Glaser & Strauss, 1967), involving coding each statement and then grouping them into similar concepts from which themes were derived.

Results

Differences by Race/Ethnicity and Peer Program Participation. As shown in Table 1, in both racially/ethnically diverse and Caucasian groups, participants in peer-run programs were significantly older than non-participants. Participants were also more likely to live in urban areas, and less likely to reside in suburban areas than non-participants. Among racially/ethnically diverse respondents only, peer-program participants had significantly less formal education than non-participants. However, there were no signifi-

cant differences by gender, employment status, or income status.

Differences in Reasons for Not Attending Peer-Run Programs. Those respondents who said they had never participated in peer-run programs were asked to select from a list of reasons for non-participation. As shown in Table 2, the most frequently cited reason for non-attendance was lack of knowledge about peer-run programs in their local area, endorsed by about half of both multicultural and white respondents. The next most frequently endorsed reasons were concern that they would not feel a sense of belonging, and preferring professional over peer-run programs. Multicultural respondents were also significantly more likely than Caucasians to be concerned that peer programs would not respect their race, culture, or ethnicity; and that their preferred language would not be spoken at peer programs. A significantly higher proportion of white respondents said they preferred professional over peer-run services as compared with racially/ethnically diverse respondents (34% vs. 19%). Finally, higher proportions of white respondents reported feeling uncomfortable with the idea of peer support

(20% vs. 10%), and feeling they already had adequate levels of support in their lives (18% vs. 9%). A higher proportion of racially/ethnically diverse respondents were concerned that they would not feel at home in peer-run programs (28% vs. 16%). However, these differences were not statistically significant and only trended toward significance.

Cultural Competency Barriers Perceived by Peer Support Participants.

Respondents who said they attended peer-run programs were asked to select from a list of barriers to cultural competency that are commonly encountered by social service organizations. As shown in Table 3, there was a high level of agreement between multicultural and white respondents about common challenges in this area. Among the three most often selected barriers by each group there was agreement on two: lack of funding to reach out to diverse communities, and lack of information about the program members' cultures. On the other hand, racially/ethnically diverse participants were more likely than white ones to feel that peer staff was unwilling to learn about different cultures, that staff failed to recognize their own need for

TABLE 2—REASONS FOR NOT ATTENDING PEER-RUN PROGRAMS AS REPORTED BY RESPONDENTS WHO HAD NEVER ATTENDED

| Reason | Caucasian Respondents | | Multicultural Respondents | |
|---|-----------------------|----|---------------------------|----|
| | N | % | N | % |
| Don't know of programs | 53 | 46 | 29 | 51 |
| Not open when convenient | 13 | 11 | 9 | 16 |
| Not comfortable with idea of peer-run programs† | 23 | 20 | 6 | 10 |
| Programs don't respect race, ethnicity, culture** | 1 | 1 | 6 | 10 |
| My preferred language not spoken* | 0 | 0 | 3 | 5 |
| Don't feel like I belong or I'm at home | 19 | 16 | 16 | 28 |
| Prefer getting help from professionals* | 39 | 34 | 11 | 19 |
| I already have all the support I need† | 21 | 18 | 5 | 9 |
| Don't like seeking help outside family† | 4 | 3 | 6 | 10 |

** $p \leq .01$, * $p \leq .05$, † $p \leq .10$

TABLE 3—PROBLEMS OF PEER-RUN PROGRAMS IN MEETING MULTICULTURAL NEEDS AS REPORTED BY PARTICIPANTS

| Nature of Problems | Caucasian Respondents | | Multicultural Respondents | |
|--|-----------------------|----|---------------------------|----|
| | N | % | N | % |
| Lack of funding to reach out to diverse communities | 116 | 49 | 61 | 51 |
| Failure to recognize need for cultural competency training** | 65 | 28 | 49 | 41 |
| Program lacked information about current members' cultures* | 74 | 32 | 52 | 44 |
| Lack of willingness to learn about staff/volunteers' different cultures ** | 38 | 16 | 35 | 29 |
| Lack of staff who speak different languages† | 121 | 52 | 50 | 42 |

** $p \leq .01$, * $p \leq .05$, † $p \leq .10$

cultural competency training, and that staff lacked information about the diverse cultures of their current membership. Finally, there was a trend toward a higher proportion of white participants than multicultural ones reporting lack of bilingual staff as a barrier in their programs.

Qualitative Findings. The web survey allowed respondents to reflect upon the cultural competency of peer services in their own words. Participants' responses reflected several themes, including struggles peer programs/groups have in being culturally responsive, strategies that successfully engage multicultural groups, and things that would make peer support non-attendees more likely to try a peer program. First, in terms of challenges in being culturally competent, respondents reflected upon the lack of knowledge, attitudes, skills, and resources among their peer programs to effectively support multicultural people. These included lack of transportation, lack of time to do effective outreach, and lack of written materials specific to racial, cultural, or ethnic minority groups.

Many respondents reflected on the shortage of training among peers to meet one another's culture-specific needs. In some cases this was due to

lack of experience with diverse groups, and not having cross-cultural training. In other cases, the problem was lack of awareness of the need for such training due to an emphasis on treating everyone alike, as in the following example.

[Everyone] was seen as "the same" and [they] did not know about how different cultural groups see/experience mental health issues.

Others felt that some peer programs/groups were not interested in developing cultural competency. As one respondent explained: "They didn't see the importance in reaching out to culturally diverse groups."

In spite of these problems, however, respondents also described positive strategies used by peer programs to engage diverse individuals. One such strategy involved inviting peers from diverse cultures to give presentations about their cultural backgrounds and encouraging their membership to ask questions. Another strategy was encouraging people to "...Just sit down and talk to [people] and listen to the stories as well."

Others suggested the importance of outreach and education through film, music, work groups, and team building exercises to get to know one another and "...how to walk in someone else's shoes." One program had reached out

to the African American community's churches, pastors, and women's groups to let them know about the program's existence and what services were available.

A group of multicultural peers who had never attended peer programs offered ideas for what might encourage them to attend. One suggested strategy was to make sure the membership already included diversity so that new members encountered "...people who look like me, have similar lifestyles, values, and cultural beliefs." Another suggestion was to tailor services for the needs of specific communities versus "...some 'canned' stuff from people way across the country."

Finally, a small but noteworthy group of respondents reported that cultural competency was not an issue in their peer-run programs. One woman commented: "As a person of color and queer identified, there have been no problems." Another explained, "I didn't recognize anything lacking."

Discussion and Implications

Discussion. A large body of literature suggests that community-based mental health programs face a number of barriers in promoting cultural competency and diversity. This study support-

ed our expectation that respondents would report that peer programs also struggle to effectively outreach and serve diverse communities, as well as our anticipation that they would encounter challenges unique to their particular setting. In our survey, current and former users of peer programs identified competency barriers that are faced by many community-based mental health programs, including financial constraints; lack of language capacity; and shortage of materials, models, and evidence about how to best support diverse groups (U.S. DHHS 1999; 2001). In whatever treatment or supportive settings these barriers are experienced, broad initiatives are necessary in order to build culturally competent traditional and peer-run mental health programs (U.S. DHHS, 2001). Nonetheless, as highlighted by our survey results, improving cultural competency at the program level does not necessarily have to be costly or large-scale in order to have an impact on the people served.

Current and former users of mutual support programs also identified issues that may be *unique* to peer programs. For example, given the informal structure typical of mutual support programs (Swarbrick, 2007), it is not surprising that survey respondents felt the programs lacked sufficient cultural competency training, as well as the resources to secure such training. Although more research is needed on the presence and impact of inadequate cultural competency training, mutual support programs may find it beneficial to tap into existing community resources and networks to secure cultural education. Additionally, that peer programs struggle to develop an organizational focus on diversity (such as via committees or formal initiatives) also would be expected given their reliance on a small staff often fully or partially comprised of volunteers. Mutual

support programs can address this need by first identifying one or two individuals interested in focusing on diversity issues, and then, expanding as their efforts are met with success. Finally, our survey respondents reported that some peer staff appeared unable or unwilling to learn more about diverse cultures, which again might reflect staff largely comprised of volunteers who have not had access to formal multicultural education. Therefore, programs might start by offering approachable, accessible cultural education through cultural potlucks, cultural music festivals, or cultural reading/film clubs.

This study also provided instructive insights into why respondents did not attend peer support programs/groups. These reasons included not knowing of peer programs in their local area, feeling uncomfortable with the idea of peer support, not believing that the program would respect their diversity, and not expecting to feel a sense of belonging. This suggests that mutual support programs might find it beneficial to engage with diverse community leaders to learn more about the specific beliefs and needs of various cultural groups, while simultaneously providing education about the advantages of peer support. Mutual support programs and groups also might consider whether their environments are hospitable to people from diverse cultures, and identify ways to help people feel welcomed through the artwork displayed, the food served, the calendar of celebrated holidays, and so forth. It should be noted, however, that these negative perceptions of peer-run programs/groups were held by respondents who had not participated in them, perhaps shedding light more on perceived than on actual hindrances. Further research is needed to explore whether or not these barriers are widely present among mutual support pro-

grams, and whether and how community outreach may be effective in overcoming them, if so.

Implications for Development of the Field. Results of this survey, and the insights it generated, were used by staff at the UIC NRTC and NAMI STAR Center to develop an assessment tool, administration manual, and accompanying resources for use by peer programs. The purpose of this tool, called Cultural Competency in Mental Health Peer-Run Programs and Self-Help Groups, is to assist peer-run programs seeking to assess their cultural competency and implement diversity action plans. The tool presents a user-friendly, simple set of procedures for programs to use in thinking about and then rating their groups or organizations in five key cultural competency domains, and then, in developing an Action Plan to enhance their diversity. Based on web survey findings, the tool helps programs to consider levels of cultural competency demonstrated in their policies, staffing patterns, staff and membership training programs, strategies for peer outreach and engagement, the services or supports offered, the program's atmosphere, and its language capacity. The tool also includes numerous training and technical assistance resources for programs seeking to improve their cultural competency. Working collaboratively, UIC NRTC and STAR Center staff conducted a pilot-test working with nine peer-run programs around the U.S. that used the tool to assess their programs, create Action Plans, and then, implement those plans and monitor outcomes over a 3-month period. Results revealed that the tool was user-friendly and easy to use, and that the assessment process led to the development of plans with attainable short-term program goals to achieve cultural competency. Based on the experiences and feedback of the leaders and membership in our pilot-

test programs, the tool was refined and is now ready for distribution by contacting staff of the UIC NRTC <http://www.cmhsrp.uic.edu/nrtc/star-center.asp> or the NAMI STAR Center <http://www.consumerstar.org>

Implications for Research. Our results set the stage for more rigorous research on the strengths and challenges that mental health peer programs face in developing and maintaining cultural competency. Future research might survey a broader population of both users and non-users of peer-run services, to explore these issues in greater depth. Other studies might address the efficacy of the assessment tool in a more rigorous design, involving the use of comparison groups and a longer follow-up period.

Study Limitations. Given that the results are based on a non-random convenience sample of respondents with access to the Internet, as well as the preponderance of women, those with high school or greater education, and Caucasians among the sample, caution must be used when interpreting these results since they are not representative of all mental health peer programs/groups or the people who staff/use them. Additionally, the survey was developed for this study (given the absence of mental health peer program cultural competency surveys), and thus, was not psychometrically validated. Nonetheless, it should be noted that, because the cultural competency practices featured in the survey are endorsed by many diversity experts, the items had high face validity. Another weakness is the self-report nature of the data collected, and the fact that we cannot verify their accuracy nor that the people completing the survey accurately represented themselves. Additionally, due to the anonymity of the survey, we also cannot guarantee that the same respon-

dent(s) did not submit separate completed surveys multiple times.

Summary. The peers who responded to this survey identified a set of common and unique barriers that peer programs face in effectively reaching out to and serving people with psychiatric disabilities from diverse communities. These findings also contributed to the development of a tool to assist peer programs in assessing and enhancing their cultural diversity and competency. While more research is needed, peer programs and groups can use the survey findings and the tool as a starting point in considering the cultural competency of their policies, staffing, services/supports, atmosphere, and language capacity, as well as how to improve competency in these areas. Such efforts will support peer-run programs and groups in their efforts to become inclusive of people from all walks of life.

References

- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11–23.
- Atdjian, S., & Vega, W. (2005). Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services*, 56(12), 1600–1602.
- Association of University Centers on Disabilities, Multicultural Council. (2004). *Instructions for assessment of organizational cultural competence*. Silver Springs, MD: author. http://www.aucd.org/docs/councils/mcc/cultural_competency_assmt2004.pdf
- Braithwaite, D. O., Waldron, V. R., & Finn, J. (1999). Communication of social support in computer-mediated groups for people with disabilities. *Health Communication*, 11(2), 123–151.
- Campbell, J. (2005). The historical and philosophical development of peer-run support programs. In S. Clay (Ed.), *On our own, together: Peer programs for people with mental illness*, pp. 17–64. Nashville, TN: Vanderbilt University Press.
- Chamberlin, J., Rogers, E. S., & Ellison, M. (1995). Self-help programs: A description of their characteristics and their members. *Psychiatric Rehabilitation Journal*, 19, 33–41.
- Cook, J. A., Copeland, M. E., Hamilton, M. et al. (2009). Initial outcomes of a mental illness self-management program based on Wellness Recovery Action Planning. *Psychiatric Services*, 60(2), 246–249.
- Cook, J. A., Grey, D. D., Fitzgibbon, G., et al. (2007). Challenges in defining respondent populations in a web survey of individuals with psychiatric disabilities. In T. Kroll, P. Placek, D. Keer, & J. Cyril (Eds.), *Disability and health: Best practices in conducting disability surveys*, (pp. 33–46). New York, NY: Nova Science Publications, Inc.
- Cook, J. A., & Jonikas, J. A. (2002). Self-determination among mental health consumers/survivors: Using lessons from the past to guide the future. *Journal of Disability Policy Studies*, 13(2), 88–96.
- Cook, J. A., Razzano, L. A., & Jonikas, J. A. (2009). Cultural diversity and how it may differ for programs and providers serving people with psychiatric disabilities. In F. E. Balcazar et al. (Eds.) *Race, culture, and disability: Rehabilitation science and practice* (pp. 115–135). Boston: Jones and Bartlett Publishers.

- Corrigan, P. (2006). Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. *Psychiatric Services, 57*(10), 1493–1496.
- Davidson, L., Tondora, J., & O'Connell, M. J. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal, 31*, 23–31.
- Davidson, L., Chinman, M., Kloos, B., et al. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice, 6*(2), 165–187.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*, 11–19.
- Glaser, B. G., & Strauss, A. (1967). The discovery of grounded theory: Strategies for qualitative research. Hawthorne, New York: Aldine Publishing.
- Goldstrom, I. D., Campbell, J., Rogers, J. A., et al. (2005). National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Research, 33*(1), 92–103.
- Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal, 23*, 333–341.
- Kessler, R. C., Nelson, C. B., McGonagle, K. A. et al. (1996). Comorbidity of DSM-III-R major depressive disorder in the general population: Results from the U.S. National Comorbidity Survey. *British Journal of Psychiatry Supplement, 30*, 17–30.
- McKenney, N. R., & Bennett, C. E. (1994). Issues regarding data on race and ethnicity: The Census Bureau experience. *Public Health Reports, 109*(1), 16–25.
- Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal, 25*, 134–141.
- McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affairs, 27*(2), 393–403.
- National Center on Cultural Competence. (no date). *Cultural Competence Health Practitioner Assessment (CCHPA)*. Washington, DC: Georgetown University.
- Onken, S. J., Craig, C. M., Ridgway, P., et al. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*, 9–22.
- Rappaport, J., Resichl, T., & Zimmerman, M. (1992). Mutual self-help mechanisms in the empowerment of former mental patients. In D. Saleebey (Ed.), *The strengths perspective in social work* (pp. 84–97). White Plains, NY: Longman.
- Salzer, M., & Shear, S. L. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal, 25*, 281–288.
- Segal, S. P., Silverman, C., & Temkin, T. (1993). Empowerment and self-help agency practice for people with mental disabilities. *Social Work, 38*(6), 705–712.
- Siegel, C., Haugland, G., & Chambers, E. D. (2004). *Cultural Competency Assessment Scale with instructions: Outpatient service delivery, agency level*. Orangeburg, NY: Nathan S. Kline Institute for Psychiatric Research.
- Solomon, P. (2004). Peer support/peer provided services: Underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27*, 392–401.
- Sue, D. W., & Torino, G. C. (2005). Racial-cultural competence: Awareness, knowledge, and skills. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Vol. 2. Training and practice* (pp. 3–18). Hoboken, NJ: Wiley.
- Sussman, L. K., Robins, L. N., & Earls, F. (1987). Treatment-seeking for depression by black and white Americans. *Social Science and Medicine, 24*(3), 187–196.
- Swarbrick, M. (2007). Consumer-operated self-help centers. *Psychiatric Rehabilitation Journal, 31*, 76–79.
- U.S. Department of Health and Human Services. (2009). Mental health support and self-help groups. *The NSDUH Report*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.
- U.S. Department of Health and Human Services. (2002). *Indicators of cultural competence in health care delivery organizations: An organizational cultural competence assessment profile*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration.
- U.S. Department of Health and Human Services. (2001). *Mental health – culture, race, and ethnicity – a supplement of mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Van Tosh, L., Ralph, R. O., & Campbell, J. (2000). The rise of consumerism. *Psychiatric Rehabilitation Skills, 4*(3), 383–409.
- Whaley, A. L. & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist, 62*(6), 563–574.
- Wright, K. B. (2005). Researching Internet-based populations: Advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services. *Journal of Computer-Mediated Communication, 10*(3), 1083–1102.
- Zhang, L. R., Snowden, L. R., & Sue, S. (1998). Differences between Asian and white Americans' help seeking and utilization patterns in the Los Angeles area. *Journal of Community Psychology, 26*(4), 317–326.

JESSICA A. JONIKAS, MA, IS MANAGING DIRECTOR OF THE UNIVERSITY OF ILLINOIS AT CHICAGO, NATIONAL RESEARCH AND TRAINING CENTER (UIC NRTC) ON PSYCHIATRIC DISABILITY IN CHICAGO, IL.

STEPHEN KIOSK, M.Div., LPC, IS DIRECTOR OF THE SUPPORT, TECHNICAL ASSISTANCE, AND RESOURCES CENTER OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS IN ARLINGTON, VA.

DENNIS D. GREY, B.A., IS A PROJECT COORDINATOR AT THE UIC NRTC IN CHICAGO, IL.

MARIE M. HAMILTON, LCSW, MPH, IS A PROJECT COORDINATOR AT THE UIC NRTC IN CHICAGO, IL.

JAMES McNULTY, AB/ScB., IS VICE PRESIDENT, PEER SUPPORT, OF THE DEPRESSION AND BIPOLAR SUPPORT ALLIANCE, CHICAGO, IL.

JUDITH A. COOK, Ph.D., IS A PROFESSOR AT THE UNIVERSITY OF ILLINOIS AT CHICAGO IN CHICAGO, IL.

CONTACT:

JESSICA JONIKAS, MA
1201 W. TAYLOR ST.
CHICAGO, IL 60612
PH: 312-413-4522
FAX: 312-355-4189
jonikas@psych.uic.edu