The continued promotion and implementation of evidence-based practices represents a significant movement in the delivery of mental health care services. Although proponents of this approach emphasize its promise to improve the quality and consistency of mental health treatment, it has yet to be embraced in nontraditional mental health care settings, including consumer-run agencies. Built on consumer values, these agencies are an important source of care for individuals with mental health needs. Due to their unique values, ideological underpinnings, and helping technologies, these programs face a special set of challenges in a service environment increasingly dominated by traditional evidence-based practice approaches. This article explores these challenges and then outlines a set of recommendations for consumer-run agencies to consider as they seek to ensure sustainability in an ever-demanding mental health service system. Recommendations are also provided for mental health administrators, planners, and policy makers.

**Key words:** consumer-run programs; evidence-based practice; mental health service delivery; mutual aid; peer support

**Introduction**

The advent and spread of an evidence-based practice (EBP) approach to mental health care has begun to transform the organization and delivery of services in the United States. Although not without its critics, the evidence-based practice paradigm is based on the notion that individuals and families facing serious psychiatric disabilities deserve access to the best services available, particularly when the appropriate scientific and clinical technology exists. EBP in mental health has
commonly been used for several purposes, including: 1) to provide practitioners with explicit tools to use when making critical practice decisions, 2) to inform and shape programming, policy, and planning decisions, 3) to promote accountability, standardized implementation, and fidelity of services, and 4) to increase cost-efficiency of service provision. Although few would argue with the importance of scientifically rigorous intervention research that is linked with consumer outcomes, the realities of community mental health practice are often demanding, and service system struggles with EBP implementation and fidelity are the norm. Simply put, the EBP paradigm brings with it opportunity and challenge in what may be best characterized as a complex and confusing mixture.

Although definitional issues regarding what constitutes evidence are abundant, the core feature of an evidence-based approach to mental health care is a systematic preference for those clinical practices for which there has been some documented empirical evidence of effectiveness in promoting positive client outcomes. The Institute of Medicine (2001) uses the following definition taken from Sackett and colleagues (2000), “the integration of best researched evidence and clinical expertise with patient values,” yet the operationalization of such values remains a neglected and misunderstood element of the equation. Viewed as simply the implementation of a set of empirically tested interventions, evidence-based practice will only offer limited benefits to actual service recipients. There is also a risk that valuable services with great potential impact but little documented evidence will be left out of the array of service choices for persons with psychiatric disabilities. Regardless of the original spirit of intent behind the paradigm shift to evidence-based practice, many of those seeking to implement and benefit from EBP will inevitably view it as an easy fix to the multidimensional problems facing mental health systems today.

Consumer-run and consumer-provided mental health services, which have been identified in recent national reports (President’s New Freedom Commission, 2003) as emerging best practices with a developing body of evidence, are based entirely upon consumer values, and as such represent a promising opportunity for bridging the gap between EBP and patient values. Yet consumer-run programs, which rely upon peer support and mutual aid as their primary helping technologies rather than traditional provider-based interventions, face a unique and daunting set of challenges in today’s era of evidence-based practice. Pressures to demonstrate accountability and to conform to an increasingly standardized and structured service system are not only immense, but are relatively new demands on consumer-run organizations.

Consumer-run programs must navigate a professionally dominated service arena and develop successful survival strategies without losing sight of their unique value base, mission, and philosophical approach. At the same time, the impact of stigma surrounding psychiatric disability remains powerful, and consumer-run programs are frequently met with resistance and distrust from traditional providers and funders who place lower value on non–professionally delivered services. Restricted funding opportunities and the increasing call for
Evidence-based practice makes the above challenges particularly demanding if not impossible for many consumer-run programs.

Anecdotal evidence and practice wisdom suggest that many innovative, effective, and indeed life-saving services are reaching those in need, but do so with little if any documentation of effectiveness. Although widely recognized by consumers as an invaluable resource and support, consumer-delivered mental health services are at significant risk of marginalization in a highly professionalized service arena. Despite growing empirical support, they have in many cases had difficulty convincing critics of their documented effectiveness, a phenomenon that may be amplified within an EBP paradigm. In order for such services to have a wider impact and be available to as many potential consumers as possible, it is critical that the scientific community broadens the dialogue around EBP, expands efforts to build evidence where there is promise, and explores new and innovative interventions as appropriate.

Successful consumer-run programs must work to meet the many challenges brought about by the arrival of EBP. This article presents a discussion of the salient issues consumer-run agencies face in the evidence-based practice environment and offers a set of recommendations such agencies might consider as they seek to ensure sustainability within the mental health service sector.

Evidence-Based Practice

Arising from a movement in physical health care settings, the shift to embrace evidence-based practices, or the “conscientious, explicit, and judicious use of current best evidence in making decisions about the care of clients” (Gibbs & Gambrill, 2002, p. 452), is perhaps one of the most significant trends in the history of mental health service delivery. By promoting the use of interventions bolstered by rigorous research, the EBP movement offers the potential to provide efficacious, uniform, and consistent care to all individuals served by mental health systems. It seeks to ensure that, despite decreasing funding and limited resources, mental health services will be effective and efficient.

Although such a movement would have been impossible in decades past, the extensive and comprehensive sum of research now available has helped to improve practitioner determinations about best practices and their potential impact on service recipients. Yet, one of the most common arguments against evidence-based practice is that it is too time consuming for practitioners, who must read and synthesize a large and complex body of research while handling the daily struggles of service delivery. In response to this complaint, Singh and Oswald (2004) cite a five-step process to guide practitioners in making evidence-based treatment decisions. Briefly summarized, the steps are formulating clear questions about who is the target and what is the target outcome, searching relevant research for answers to these questions, evaluating the results in practice, and, finally, evaluating the effect of the treatment on clients. In tackling the tasks of finding and evaluating relevant research, a popular eviden-
tiary hierarchy begins with a systematic review of randomized clinical trials (considered the best evidence), then moves to single randomized clinical trials, cohort studies, outcomes research and ecological studies, case-control studies, and concludes with expert opinion, considered the least useful form of evidence (Singh & Oswald, 2004).

For adults with psychiatric disabilities, several methods of care have been supported by strong research evidence, and have thus been designated as evidence-based practices. These include assertive community treatment, psychotropic medication prescribed within established dose and frequency criteria, training clients to manage their own illness, supported employment, integration of dual diagnosis treatment, and increasing family members’ knowledge about mental illness (Phillips et al., 2001; Drake et al., 2001).

Yet despite its accomplishments and admirable intentions, the EBP movement may be in danger of devolving into a cost-cutting, manualized way of offering services. Those implementing EBP should acknowledge implicit assumptions underlying how evidence is defined, developed, and disseminated, as well as factors related to professional ownership and discipline-specific control. A very real group of dangers may confound the adoption of EBP, including inflated evidentiary claims (Gibbs & Gambrill, 2002), misunderstandings about the meaning of EBP (Webb, 2001), lack of agreement about implementation strategies, and lack of attention to individual practitioner, organizational, and context-based factors (Videka, 2003). Even more potentially damaging, the EBP paradigm, with its roots in health care, can be viewed as an extension of the medical model of care, which Munetz and Frese (2001), along with many others, suggest has been overly paternalistic and alienating to consumers. Also of particular concern to many is the canonization of a core set of evidence-based practices at the expense of alternative services.

Consumer-Run Programs

Over the last 30 years, mental health consumers have moved from limited patient/recipient roles to involvement as professionals in the mental health system (e.g., consumer case managers and consumer case aides). But particularly revolutionary is the phenomenon of consumers running their own not-for-profit service programs, a development characterized by both service role and organizational innovation (Chamberlin, 1990; Mead, Hilton, & Curtis, 2001). The delivery of direct care and supportive services by mental health recipients in such agencies signals a powerful trend in mental health care, in which roles and responsibilities are shared by consumers and nonconsumers alike. The recognition of such individuals as being capable of participating in the delivery of services suggests a larger symbolic representation of how we as trained professionals view the human potential of individuals once labeled as patients or clients.

Although efforts have been made both to delineate the core elements of consumer-operated services (Consumer Operated Service Program, 2001; Holter Mowbray, Bellamy, MacFarlane, & Dukarski, 2004), and to document their empir-
lcal evidence (Solomon & Draine, 2001), much remains to be answered. Consumer-run programs often function in parallel with traditional systems of care, creating in effect a de facto mental health system by and for consumers with a focus on empowerment and a reduction in the stigma associated with having a mental illness (Hodges & Segal, 2002; Segal, Silverman, & Temkin, 1995). As much as we have come to understand about the unique qualities of peer relationships and mutual support mechanisms, there is considerable room for improved clarity and articulation about the standards and benchmarks of quality consumer-delivered services.

Consumers delivering supportive mental health care provide services from a position of expert authority (that of shared life experience) and offer new possibilities of engagement with individuals underserved by traditional models of care. By virtue of the fact that consumer-providers have been through similar experiences, they offer a helping voice that may be heard more clearly than that of traditional professional providers. Potential benefits for service recipients working with consumer-providers include empowerment, social network development, improved social functioning, and increased hope (Solomon, 2004). Service flexibility, choice, and participatory program control can also be seen as unique benefits for consumers in consumer-run programs. It has further been theorized that consumer-providers can role model both recovery and successful workforce participation. Simply having access to a cadre of consumer-workers sends a powerful message to mental health service recipients that there is light at the end of the tunnel, that recovery may be possible, and, further, that they themselves have something valuable to offer others. Finally, benefits arising from consumer-delivered services not only impact those receiving services, but also the consumer-providers themselves and the larger mental health systems which interact with said providers (Salzer & Shear, 2002; Solomon, 2004).

The consumer-run service trend suggests that clients can and, in fact, must be given new empowered roles within the context of the direct service interaction. The trend also implies that mental health services need not be the sole purview of a traditionally empowered and professionalized workforce. Consumer-run programs can be viewed as complementary rather than competitive services with traditional providers. Recognizing that both mental health consumers and traditional providers have distinctive and important roles to play in a comprehensive service delivery system can lead to understanding and acceptance and ultimately to valuable new collaborative partnerships (Hodges & Hardiman, 2004; Hodges, Markward, Keele, & Evans, 2003).

Effectiveness of Consumer-Run Programs

There appears to be a growing body of evidence that consumer-run programs and consumer-provided services are valuable for persons with serious psychiatric disabilities (Solomon, 2004; Salzer, 2002; Yanos, Primavera, & Knight, 2001). Although some researchers have begun examining the effectiveness of services delivered in consumer-run settings, the literature in this area has not moved far
beyond descriptive studies, the occasional published discourse, and calls to action. However, the existing body of evidence is promising and suggests that future research in this arena may be helpful in building a stronger case for consumer-delivered services. Salzer (2002) reports the presence of a “growing, albeit limited body of research that has found consistently positive results” (p. 6) for consumer-provided services. Two prominent examples of recent research reviews in this area were conducted by Solomon and Draine (2001) and Van Tosh and del Vecchio (2000).

The research on consumer-provided services has begun to provide a comprehensive picture of the types of services offered, characteristics of participants, philosophical tenets, and the central working mechanisms behind such services. Positive outcomes associated with participation in consumer-run programs include, but are not limited to: improved quality of life (Chamberlin, Rogers, & Ellison, 1996); improved problem solving, satisfaction, and enhanced social support (Mowbray & Tan, 1993); empowerment (Segal, Silverman, & Temkin, 1995); and hope (Hodges & Segal, 2002).

Despite the promising picture suggested by such findings, significant limitations plague the research on consumer-run programs and consumer-delivered services in mental health. First and foremost, unique setting, service, and provider characteristics often prohibit or at least limit the use of the more rigorous study designs available today. The complexities of these factors suggest that consumer-run organizations may be more suited to qualitative, narrative, and participatory research designs (MacNeil & Mead, 2003). Difficulties in access, recruitment, and retention of potential participants exist in many consumer-run programs due to mistrust of researchers among consumers. Most importantly, consumer-providers at consumer-run programs have not been involved to a significant degree as research partners, or in the conceptualization, design, and implementation of studies.

Definitions of Evidence-Based Practice in Consumer-Run Programs

The popularity of evidence-based practice and the proliferation of consumer-run agencies make their intersection a natural and important starting point for both research and service delivery. Yet the very concept of evidence-based practice, much less how to define and implement it, has been viewed as problematic by many consumer-run programs. The research upon which much of the evidence base in mental health has been developed has examined delivered by a traditional non–consumer mental health workforce. Most of the research was also conducted prior to the advent of the recovery model and approach to mental health (Anthony, Rogers, & Parkas, 2003), a central ideological foundation for most consumer-run programs. Further, the research methods given highest priority within the EBP paradigm are often not appropriate or feasible for consumer-run settings. Thus, despite increased recognition as an emerging best practice, consumer-run organizations must struggle with how to develop meaningful ways to provide services congruent with the principles of EBP.
Consumer-run programs are built on a set of service values and philosophical tenets that by design enables them to target a broader, more flexible range of potential outcomes than those measured in more traditional settings. Indeed the consumer-centered ideology and expanded approach to both services and outcomes are what set these organizations apart from traditional mental health programs. If the expected consumer outcomes are in fact radically different than those captured by accepted standardized measures, how are such programs to fit in with the demands of an evidence base that predominately values quantitative, experimental, or quasi-experimental studies? The critical question becomes: How can consumer-run programs best justify and sustain their own service delivery capacities in a time of shrinking budgetary support and increased accountability to traditional evidentiary standards?

As a start, consumer-run programs need to define evidence-based practice in their own context and to identify the resulting implications. Faced with the evidence-based practice challenges discussed above, programs have several potential options. One choice may be to seek support opportunities not tied to evidence-based practice funding and thus continue to provide services outside of the EBP discussion. However, if consumer-run programs seek to maximize access to county, state, and federal funding and build sustainable futures, it would behoove them to begin to thoughtfully address ways to tackle the challenges of integrating an evidence-based practice approach to service delivery. Consumer-run programs choosing to do so will also be enhanced by their strengthened commitment to service accountability and improved ability to document outcomes.

A particularly useful method of integrating an evidence-based practice approach at consumer-run programs may be to identify and document those outcomes and indicators signifying program effectiveness. This will help create a unique evidence-based model of practice specific to consumer-run agencies that can serve as a model for future program evaluation and other research. Several first steps have been taken in this direction. Holter et al. (2004) have surveyed national experts on consumer-run services to gauge their opinions on criteria critical to consumer-run programs. Those criteria identified as most important included consumer control, consumer choice and opportunity for decision making, voluntary participation, and respect for consumers by staff. Similarly, Salzer (2002) has offered best practice guidelines that address pertinent issues purported to be applicable across a variety of consumer-provided service settings. Finally, Solomon (2004) offers a set of critical ingredients that make up peer support and/or peer-delivered services, arguing that these elements are a necessary feature of effective consumer-provided services.

By emphasizing the development of fidelity standards and practice guidelines within consumer-run programs, the approaches above offer a useful bridge between a focus on empirical evidence and that on consumer values. They may also be viewed as parallel to the practice guideline movement in social work (see Rosen & Proctor, 2003), which proposes guidelines as a “requisite tool” (p.5) for implementing EBP. Applied to consumer-run program settings, practice guidelines
might offer a practical hands-on means for programs to deliver services that are replicable in other locations, have some empirical grounding, and are of maximum utility to participants.

These approaches can also provide a concrete example of how EBP concepts can be broadened to incorporate nontraditional varieties of care delivery. However, a strategy to develop standards, criteria, and practice guidelines for consumer-delivered interventions may be met with ambivalence by consumer groups who fear a loss of control and the forced implementation of cookie cutter services. To counter this possibility, actual consumers (including those who are providers, recipients, and researchers) should be involved at every level of the planning and development process.

Often perceived as less important within the research community, local setting-based knowledge and experience have long been of great importance to consumer-run programs and some fear that with an acceptance of standards (and by extension the EBP paradigm) comes a loss of flexibility and a devaluation of local practice wisdom. The dominant challenge for these groups may be how to best find a meeting ground between the benefits offered by integrating an EBP approach and those offered by maintaining sole commitment to local knowledge and organization-based values.

We agree with Tracy’s (2003) contention that more resources should be allocated for researching consumer-run services. Tracy contrasts consumer-run services with evidence-based practice by labeling them as value-based services, or those services with high consumer satisfaction ratings but supported by limited scientific evidence about their effectiveness. The perceived lack of scientific evidence and challenges conducting empirical studies are recurring problems facing consumer-run agencies in this era of evidence-based practice. Recalling the hierarchy of evidence detailed in a previous section, most believe that the best evidence is from randomized clinical trials. However, the outcome criteria of such trials tend to focus only on traditional measures of effectiveness, including inpatient hospitalization, symptom reduction, decreased length of inpatient stay, and increased community tenure for mentally ill people (Drake et al., 2001; Anthony, Rogers, & Farkas, 2003). Thus, as consumer-run programs consider moving forward with efforts to define EBP within their own context and frameworks, it will be important to look at both target outcomes and the methods used to evaluate them.

Challenges and Barriers for Consumer-Run Programs

It has been argued that a defining characteristic of populations served by consumer-run programs may be their shared negative experience with the traditional mental health system (Bassman, 2001; Chamberlin, 1990; Nelson, Ochocka, Griffin, & Lord, 1998; Van Tosh, Ralph, & Campbell, 2000). Coupled with the fact that many consumer-run programs are a direct outgrowth of the antipsychiatry and consumer rights movements, it is only natural that participants have developed a
distrust of mental health professionals and researchers (Powell & Cameron, 1991). Inherent value differences and philosophical or ideological challenges are the primary barriers to consumer-run programs integrating an EBP approach. Within this larger category exist subcategories of differences between consumer-run programs and traditional mental health services. These include definitional issues, research and knowledge base challenges, structural and organizational challenges, and controversies and problems with the EBP concept itself. Each of these subcategories is described at greater length below.

General Philosophical/Ideological Challenges Many consumer-run programs have developed as grassroots alternatives to traditional services and have held anti-establishment views that may foster resentment toward any efforts to integrate an EBP framework (Chamberlin, 1990; Van Tosh, Ralph, & Campbell, 2000). EBP may be perceived as paternalistic, overly prescriptive, being dictated “from above,” or being forced on consumers by the same professional system that has previously mistreated them. These antiprofessional attitudes often result from a fundamental difference in etiological and epistemological views of mental illness. For example, participants at consumer-run programs often resent traditional disease explanations of mental illness as stigmatizing, disempowering, and overly illness-focused, instead opting for flexible definitions that emphasize personhood and hope for recovery (Nelson, Ochocka, Griffin, & Lord, 1998). Negative attitudes among consumers are not merely political badges; they are often forged by genuinely traumatic personal experiences of mistreatment and emotional and/or physical harm. As such, the professional system needs to place higher value on consumer input concerning objections to evidence-based practice. Otherwise, we run the risk of facing an insurmountable obstacle: consumer-run programs perceiving evidence-based practice as unresponsive to their unique service structures and goals.

Consumer-run programs may also view evidence-based practice as philosophically antithetical to their programs, in which consumer choice and service flexibility are of central importance. Consumers may also worry about the co-optation of the consumer-run service model as they begin to accept direction and control from the traditional system. An important step for consumer-run programs in this area will thus be to fully develop and articulate their own values and ideological stances in order to best assess how (or if) to integrate an EBP approach in their programs.

Definitional Challenges Integrating an EBP framework for services necessitates clearly defined outcomes that can be observed and measured. As such, traditional outcome measures, typically based on medical models and diagnostic classification systems that many consumers eschew on philosophical grounds, are not always adequate for consumer-run programs. New and broadened outcomes and indicators need to be identified. As an example, one outcome valued by consumer-run programs may simply be program or agency attendance (Lieberman, Gowdy, & Knutson, 1991; Mowbray, Robinson, & Holter, 2002). Consumer-run programs
often target services for individuals for whom active engagement in traditional systems of care has been problematic, thus rendering attendance as a valuable outcome and potentially critical factor in predicting consumer-run program success. Although attendance alone may not be valued as highly by professional providers and/or researchers, to overlook it in consumer-run programs would be arrogant and possibly dangerous.

It is essential that EBP-related service outcomes not be defined for consumer-run programs, but rather in conjunction with consumer-run programs, or by consumer-run programs alone. Campbell (1996) argues that systems of accountability in mental health care will require collaborative participation in the task of defining outcomes and outcome indicators. True collaboration between the two systems of care is a delicate and deliberate process described in more detail in Hodges and Hardiman (2004). This approach is consistent with the “nothing about us, without us” approach adopted from the disability and consumer rights movements.

Campbell and Leaver (2003) note, “It is critical that the role community-based peer support systems play in the rehabilitation of persons with psychiatric disorders be rigorously defined and the functions and competencies of peer providers be established” (p. 21). Such rigorous definition has proven challenging for many consumer-run programs to date, and little if any support has been provided by mental health systems. To successfully define evidence-based practice in consumer-run settings, programs will need to develop outcome criteria, practice guidelines, skill competencies, and logic models supporting consumer-provided interventions. Consumer-run programs should also seek to standardize and implement well-defined training and support procedures for consumer staff.

Research and Knowledge-Base Challenges At best there has been ambivalence from consumer-run programs regarding research and researchers. Often perceived as emissaries of the professional system, researchers bring with them professional priorities and mindsets, and may risk devaluing the experiential knowledge of consumers. Different research methodologies are needed (qualitative/narrative and participatory action methods in particular) to capture the intricacies of consumer-run programs and their evolving service technologies (Powell, 1993; Van Tosh, Ralph, & Campbell, 2000). These research methods may be able to more adequately capture the complexity of a consumer-run program and better hear the consumer voices than more quantitatively oriented approaches.

Although there is an abundance of research on the nature of consumer-run services, and growing research on their effectiveness, this research has historically been conducted with little or no consumer input into the conceptualization, design, data collection, analysis, interpretation, and writing of the research findings. This is in complete opposition to the mission and values of consumer organizations, which call for inclusion in all levels of mental health treatment and planning, including research. Participatory involvement and collaboration should apply to research, treatment, and policy decisions. It is paramount that consumer
voice be fully represented in research (Campbell, 1999; Cohen, 2000; Kaufmann, 1993; Kaufmann & Campbell, 1994; Rapp, Shera, & Kisthardt, 1993).

**Structural/Organizational Challenges** Consumer-run programs differ structurally from traditional community mental health programs, which usually have a flattened rather than hierarchical organizational makeup, although over time more formalized consumer-run programs begin to resemble traditional structures (Mead, Hilton, & Curtis, 2001). Traditional agencies generally rely more on bureaucratic and technological means of authority, while consumer-run programs place more emphasis on the shared life experience of their members (Davidson et al., 1999). These differences in structures often make collaboration and, thus, the use of a coherent set of EBP-related outcome measures problematic. A possible solution for this problem would be the placement of consumer advocates in the professional agencies, and vice versa. This beginning step of collaboration between the two structures may help each side understand the unique facets of implementing EBP approaches for the other type of program.

Another structural issue is the fundamental nature of the helping technology used in each type of program. Traditional mental health agencies rely on educated, trained personnel to deliver case management, therapeutic, and medical services to their clients. Consumer-run programs rely on principles of peer helping and mutual support (Davidson et al., 1999). Helping interventions within consumer-run programs are conceptualized as mutually reciprocal, allowing the service recipient to gain, but also granting social standing, legitimacy, and a sense of esteem and purpose to the helper (Mead, Hilton, & Curtis, 2001). In contrast, the helping process at traditional agencies is hierarchical, power-laden, and unidirectional. This core difference in service provision has profound impacts on how researchers conceptualize the process, define indicators and outcomes, and engage in research and/or evaluative activities (Van Tosh, Ralph, & Campbell, 2000). More rigorous study is necessary to better understand the impact of these differences, and to generate knowledge about the complexities of the peer service exchange.

**Controversies and Problems with EBP** It should be noted that the use of an EBP framework in mental health, as in allied fields, has not been met with unanimous agreement. Rarely does the implementation of EBP follow a smooth, easy path. Mental health consumers have been among the most vocal opponents of the transition to evidence-based practices, fearing that such a change would lead to limited options and the defunding of programs that are indeed quite effective, yet lacking scientific evidence to date. Some have challenged the evidence, suggesting that it only tells a piece of the puzzle, ignores valuable local knowledge and expertise, and most importantly is built on traditional outcomes not able to capture the effectiveness of consumer-provided services. Even some EBP supporters have recognized the need for a broader vision that must include “consumer-oriented outcomes such as: independence, employment, satisfying relationships, and good quality of life” (Drake et al., 2001, p. 180).
Critics have suggested EBP is more a political tool than an aid to effective practice. Tanenbaum (2003) studied the growing influence and utilizations of EBP in public mental health settings and concluded that “Its practical strengths may turn out to be less than its strengths as a public idea in the formulation and dissemination of mental health policy” (p. 287). This may reflect the mission statement phenomenon whereby something is politically expeditious but does not actually reflect practice and agency-based reality. Burton and Chapman (2004) go even further in critiquing EBP, stating that it “falters at every step, from the production of evidence to its use by practitioners” (p. 56).

EBP can also be problematic if efforts are not made to factor in setting, practitioner, and contextual characteristics affecting intervention implementation and outcomes. Videka (2003) locates this challenge as one of applying nomothetic evidence in idiographic practice settings. Similarly, Zayas (2003) calls attention to service delivery factors and their importance in the development of evidence-based practice guidelines. Such considerations argue for thoughtful attention to practice-based realities, including organizational culture and setting-specific factors. Burton and Chapman (2004) as well as others (see Gellis & Reid, 2004) have suggested the need for alternative and/or expanded EBP frameworks built on broader outcomes and conceptualizations. An alternative framework is clearly necessary for consumer-run programs, yet in the meantime programs face challenges and decision-making opportunities that cannot be ignored.

Suggested Steps for Addressing EBP in Consumer-Run Programs

Mindful of the challenges identified above, we offer the following set of suggested steps for consumer-run programs willing to address the implications of the evidence-based practice paradigm in their own settings. These steps are not intended as a solution to the funding and service challenges associated with evidence-based practice, but rather as a set of recommended considerations that may be of utility for mental health systems and consumers alike.

1. Consumer-run programs should begin a dialogical process first within their own organizations, and then extend outward in concentric circles to include various stakeholders (staff, recipients, board members, funders, and relevant community partners). Some key questions might include: What is evidence? What is knowledge? What does EBP mean for us? How will it impact our services? What assumptions are we making? What assumptions underlie the evidence?

2. Using an action-oriented participatory process, consumer-run programs should decide:
   a. Whether or not to integrate an EBP approach in their organizational and service contexts.
   b. How to best integrate an EBP approach within their setting/context.
   c. How to contribute to the development and growth of a body of evidence supporting consumer-provided services.
d. How to maintain fidelity to consumer values.
e. How to best articulate and legitimate their own body of practice knowledge.

3. Consumer-run programs should seek to participate in local, state, and even federal planning discussions about EBP.
4. Consumer-run programs should seek access to supports around EBP and practice guidelines, including education, implementation issues and strategies, research skill development, and evaluation capacity building.
5. Regardless of any decision whether or not to integrate an EBP approach, consumer-run programs should participate in their own outcome definition, measurement, and ongoing service evaluation activities.
6. Consumer-run programs should work toward the development of standards of care, indicators of success, and practice guidelines, accompanied by well-articulated training and ongoing staff support mechanisms.
7. Consumer-run programs should seek to engage in collaborative ventures with traditional mental health providers, as long as these activities respect consumer philosophies and the need to maintain a value-driven approach to peer support services within consumer-run programs.
8. Consumer-run programs should seek assistance from other successful consumer-run programs and combine intellectual and service resources when appropriate.
9. Consumer-run programs should utilize technical assistance support services from consumer advocacy groups, when available and appropriate.
10. Consumer-run programs should advocate for increased research funds and attention to consumer-delivered service models.
11. Consumer-run programs should keep an eye toward innovations in service delivery and incorporate ongoing evaluation activities as a means to build effectiveness of new technologies and methods.

Traditional mental health administrators, planners, funders, and those espousing the adoption of the EBP paradigm also bear some responsibility for improving the outlook for consumer-run programs. The following recommendations may help such entities as they seek to maintain strong commitment to the principles of evidence-based practice, while also incorporating consumer values:

1. Consumers should be included in all stages of planning and policy development. Caution against the use of tokenism should be taken into account. Having a lone consumer voice on a planning committee does not signify participation and/or collaboration with consumers.
2. More research funds should be devoted to the study of consumer-run programs and other consumer-delivered service modalities.
3. More funds should be targeted toward promoting the development and ongoing support of consumer-run programs.
4. Education about consumer-provided services and consumer-run programs should be provided to traditional mental health programs.
5. Collaboration with consumer-run programs should be encouraged (for example through funding and program incentives). Partnerships need to extend beyond service delivery activities to include research, development, and planning collaboration.

6. State and local mental health authorities implementing an EBP approach should seek to broaden definitions of evidence and factor in considerations such as consumer values, local knowledge, and setting-based barriers to implementation of studies.

7. An expanded range of research designs and methods should be valued and incorporated into EBP hierarchies, particularly as traditional experimental approaches may not be well-suited for consumer-run programs and other consumer-delivered services.

8. Consumer-researchers should be included as partners in research activities aimed at studying consumer-run organizations.

9. Efforts to recruit consumers in recovery to be trained as doctoral level researchers should be aimed at graduate and professional schools (Frese, Stanley, Kress, & Vogel-Scibilia, 2001).

10. Mental health authorities and other funders should consider prioritizing additional money to support research and capacity development among consumer-run programs.

Conclusions

One might conclude that we have entered a perilous age in which consumer-run programs have been set up only to fail in their bids for sustainability and perceived relevance in a new era of EBP and research-guided mental health services. We strongly urge against this assumption and have outlined the above recommendations as a cautionary message to mental health funders and program planners beginning to implement evidence-based practice approaches to mental health care. Consumer-run programs would benefit from starting to address the realities of the new EBP era and its potential impact on the sustainability of their services. We believe that consumer-run programs can indeed benefit from integration of EBP concepts and principles, but also that there needs to be a radical rethinking about how to broaden outcomes and research methodologies, while honoring consumer values.

Questions raised by the challenges here will not be easily answered; however, the dialogue to be opened by the evidence-based practice concept is critically important as mental health systems strive for improvement and successful transformation. Through this dialogue, it will be possible to grapple with the important issues of science, accountability, and genuine attention to consumer values. Gambrill (2003) argues that “EBP encourages honest brokering of knowledge and ignorance” (p. 53). Such brokering must include consumers of services, and particularly those working in nontraditional settings like consumer-run programs. We agree that the shift toward an evidence-based paradigm is a worthy goal for mental health systems, yet we warn against the dangers of viewing it as an easy
fix. Achieving fidelity to the rigors of an evidence-based practice model of mental health service delivery is a complex endeavor and should only be done with careful attention to consumer values, and participatory involvement at all levels with consumers, families, and their advocates.

References


---

**Evidence-Based Practice in Consumer-Run Programs**


