Fostering the Community Participation of Individuals With Psychiatric Disabilities: Effectiveness of a New Peer-Led Photovoice-Based Intervention

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Objective: Having meaningful social roles and full community participation have been examined as a central tenet of the recovery paradigm. We undertook this study to test a new multimodal, peer-led intervention, which we have developed with the aim of fostering the self-efficacy of individuals with psychiatric disabilities to pursue involvement in community activities of their choice. *Method:* We evaluated the effectiveness of the 6-month manualized peer-delivered "Bridging Community Gaps Photovoice (BCGP)" program with a multisite randomized trial ($N = 185$), with recipients of services at five community mental health programs. Mixed-effects regression models were used to examine the impact of the program on community participation, loneliness, personal stigma, psychosocial functioning, and personal growth and recovery when compared to services as usual. Individuals who were randomized to the BCGP intervention were also invited to participate in exit focus groups, exploring the program's perceived active ingredients of mechanisms of impact. *Results:* Participation in the BCGP program facilitated ongoing involvement in community activities and contributed to a decreased sense of alienation from other members of the community due to internalized stigma of mental illness. In addition, greater attendance of group BCGP sessions had a significant impact on participants' sense of self-efficacy in pursuing desired community activities. *Conclusions and Implications for Practice:* This study provided initial evidence about the promise of the BCGP program in enhancing community participation. Its implementation in community mental health agencies can further expand the recovery-oriented services provided to people with psychiatric disabilities.

Impact and Implications
This study provided initial evidence about the promise of the peer-delivered "Bridging Community Gaps Photovoice (BCGP)" program in enhancing the community involvement of people with psychiatric disabilities and decreasing their sense of alienation from other community members due to concerns about prejudice and discrimination. The BCGP program has the potential to contribute to the portfolio of recovery-oriented services as it has the potential to foster individuals' self-determination to pursue a broad spectrum of desired activities as equal community members.

Keywords: psychiatric disabilities, community participation, social connectedness, loneliness, photovoice

Reclaiming valued social roles is a central tenet of recovery for individuals with psychiatric disabilities (Anthony, 1993) and a path to full community participation (Burns-Lynch et al., 2016; Millner et al., 2019; Yanos et al., 2018). Recently, community inclusion has been viewed as a social determinant of health in this population (Salzer, 2021).

Community participation is a broad construct defined as natural engagement with others (Salzer et al., 2014) across multiple social

domains (Terry et al., 2019). It encompasses both "physical community participation" (i.e., engagement in community "goods and services") and "social community participation" (i.e., social interactions, civic involvement; Yanos et al., 2018). Research also distinguishes between objective aspects (i.e., amount of community activities, social supports) and subjective aspects (i.e., perceived social connectedness, sense of belonging) of community participation (Ma et al., 2020; Rogers et al., 2021; Salzer et al., 2014).

Community asset mapping is a relatively recent approach (Kretzmann & McKnight, 1993), examining community participation from the point of view of community and personal assets rather than deficits (Lightfoot et al., 2014). As a strength-based approach, community asset mapping is grounded in the principles of empowerment, capacity building, inclusiveness, and collaboration (Kramer et al., 2012). Public health research is increasingly examining community assets for health (Sáinz-Ruiz et al., 2021).

There is strong evidence that individuals with psychiatric disabilities experience social isolation and marginalization (Eglit et al., 2018; Lim et al., 2020; Wang et al., 2017, 2018), which may lead to loneliness (Mann et al., 2017; Michalska da Rocha et al., 2018), depression and poor quality of life (Lim et al., 2020), and suicidality (Batty et al., 2018). Research also suggests that community engagement is a predictor of recovery (Burns-Lynch et al., 2016; Kaplan et al., 2012), as it may foster a sense of relatedness, meaning in life, competence, and autonomy (Hine et al., 2018; Millner et al., 2019), and may reduce the risk of disability associated with long-term psychosis (Bjornestad et al., 2017). More frequent engagement in community activities has been associated with diminished psychological distress and improved sense of belonging (Terry et al., 2019).

Public prejudice and discrimination associated with mental illness represent a critical factor impeding community integration (Bromage et al., 2019; Corrigan et al., 2012; Pescosolido, 2013; Salzer & Baron, 2016), as they influence all aspects of personal stigma among individuals with psychiatric disabilities, including experienced, anticipated, and internalized stigma (Gerlinger et al., 2013; Russinova, Mizock, et al., 2018). Research has consistently demonstrated that internalized stigma is associated with reduced hope, self-esteem, self-efficacy, empowerment, quality of life, and social support (Livingston & Boyd, 2010), and contributes to worse social functioning (Brohan et al., 2010; Link et al., 2001; Muñoz et al., 2011). Other barriers to community integration include poverty, limited resources, and lack of transportation (Byrne et al., 2013; Corrigan et al., 2015; Gonzales et al., 2018; Kloos & Townley, 2011).

The importance of community inclusion has prompted efforts to develop interventions targeting the social isolation of people with psychiatric disabilities (Hare-Duke et al., 2019; Litwiller et al., 2017; Ma et al., 2020; Mann et al., 2017). While social functioning and loneliness have been targeted either by specific or broader psychosocial interventions (Mann et al., 2017), evidence about their effectiveness has been limited and inconclusive (Hare-Duke et al., 2019; Ma et al., 2020). For example, two randomized studies reported no significant effect of a supported socialization intervention, which consisted of assigning a peer or nonpeer volunteer to assist with social and recreational activities (Davidson et al., 2004; Sheridan et al., 2015); a benefit was reported only in secondary analyses accounting for exposure to the intervention and only when the assigned volunteer was a nonpeer (Davidson et al., 2004). A more recent approach employing trained community navigators to provide guidance and support around engagement in community activities showed promise

in reducing loneliness based on qualitative data from a small randomized feasibility study conducted only with individuals with complex anxiety and depression (Lloyd-Evans et al., 2020). Last, there has been interest in the United Kingdom in "social prescribing," which consists of a primary care provider making referrals to community-based activities to improve health and well-being; however, evidence about its effectiveness in increasing community activities is lacking (Husk et al., 2020).

In summary, despite growing efforts to develop interventions enhancing the community participation of people with psychiatric disabilities, to date there are no reports indicating significant effects on targeted outcomes. In addition, these interventions only target specific aspects of community participation, such as social and recreational activities (Davidson et al., 2004; Sheridan et al., 2015) or loneliness (Lloyd-Evans et al., 2020). Overall, there is a strong need of effective interventions that can promote the full community inclusion of people with psychiatric disabilities.

We initiated the development of a peer-led intervention to promote the involvement of people with psychiatric disabilities in personally meaningful community activities guided by our prior success in using Photovoice research methodology (Wang & Burris, 1997) in an innovative way, namely, as a therapeutic component in complex recovery-oriented psychosocial interventions (Russinova et al., 2014; Russinova, Gidugu, et al., 2018; Russinova, Mizock, et al., 2018). More specifically, we envisioned that the new intervention would build upon our "Anti-Stigma Photovoice" peer-led group intervention, which has shown promise in reducing internalized stigma and promoting proactive coping with public prejudice and discrimination (Russinova et al., 2014). The conceptual model (Figure 1), which guided the development of the new intervention titled "Bridging Community Gaps Photovoice (BCGP)," highlights prejudice and discrimination as a major barrier and the utilization of community resources as a key facilitator determining the community participation of people with psychiatric disabilities. This conceptual framework also integrates the theoretical underpinnings of Photovoice methodology informed by both Freire's critical consciousness theory and feminist theory (Strack et al., 2022; Wang & Burris, 1997), and the empowerment and strength-based principles of the community asset mapping approach (Kramer et al., 2012; Kretzmann & McKnight, 1993). The conceptualization of the BCGP program epitomizes Dr William Anthony's vision of recovery as the process of full societal inclusion of people with psychiatric disabilities through their involvement with personally meaningful activities (Anthony, 1993) and the fostering of their self-determination and sense of personhood (Anthony, 2004). It also aligns with Dr Anthony's vision about the importance of the peer providers workforce in promoting recovery outcomes (Anthony & Ashcraft, 2006).

We developed and tested the BCGP program as a 6-month peer-led intervention with group and individual support components. Consistent with the program's primary purpose, we hypothesized that participants would experience greater increases in both the objective (i.e., amount of community activities) and subjective (i.e., self-efficacy) dimensions of community participation when compared to individuals not receiving the intervention. We also hypothesized that the BCGP program may have a positive impact on other recovery-related outcomes, namely, that participants would experience greater decreases in their sense of loneliness and personal stigma, and greater increases in their capacity to cope with public stigma, in their psychosocial functioning and personal

Figure 1

Conceptual Model Informing the Development of the Bridging Community Gaps Photovoice (BCGP) Program
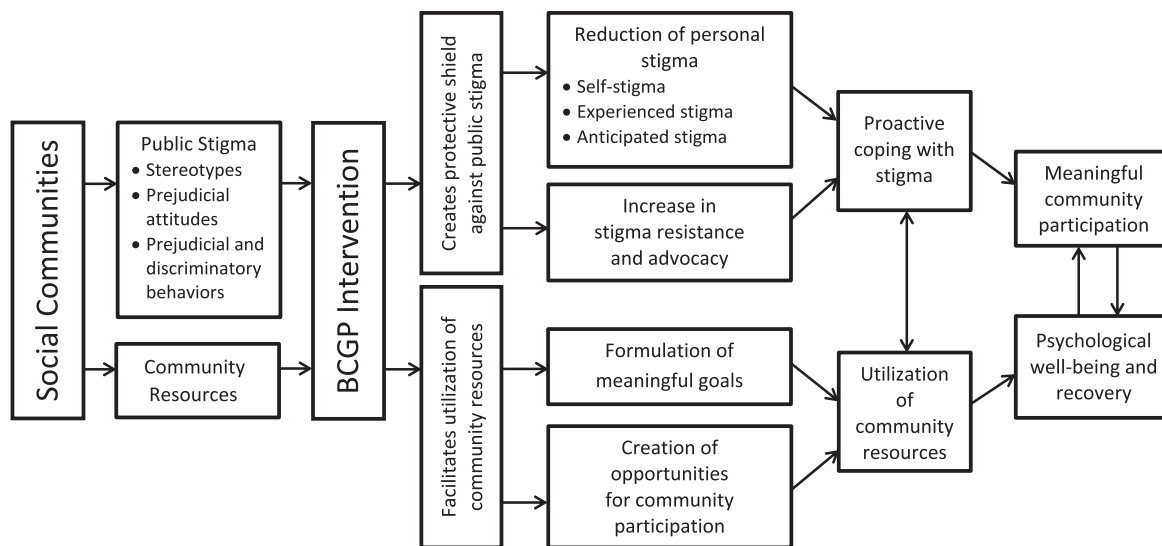
growth and recovery when compared to individuals not receiving the intervention.

Method

Study Overview

The effectiveness of the BCGP program when compared to Services-as-Usual (SAU) was tested as part of a multisite randomized clinical trial (RCT; $N = 185$), which included five assessments—baseline, 3-month (interim), 6-month (post-treatment), 9- and 12-month (posttreatment follow-ups) and an exit focus group for participants in the experimental condition. All research procedures and materials were approved by the institutional review boards overseeing the study.

Sample

Study eligibility criteria included individuals who (a) were 18 or older, (b) were recipients of services at each recruitment site due to having a diagnosis of mental illness (5th ed.; *DSM–5*; American Psychiatric Association, 2013), (c) were interested in enhancing their community participation, (d) were not currently receiving individual peer support services, (e) were able to read and write in English, and (f) were able to provide informed consent. In total, 197 individuals were enrolled in the RCT; however, 185 participants were included in the analyses since nine individuals declined to complete the baseline assessment, were not randomized, and were withdrawn from the study; one individual was determined ineligible and was withdrawn, and two individuals requested withdrawal from the study.

Recruitment Sites and Procedure

Participants were recruited among the service recipients at the following sites: a university-based recovery-oriented rehabilitation program in Boston, Massachusetts; a recovery-oriented rehabilitation program of a large mental health provider in Denver, Colorado; an outpatient program of a large mental health provider and a partnering clubhouse in Bridgeport, Connecticut; and a clubhouse in Wakefield, Massachusetts.

Recruitment flyers were posted at each research site. In addition, clinical staff affiliated with the study made presentations at site-specific meetings and events to solicit interest in study participation. Potential participants at each site were directed to a designated services coordinator who provided a brief description of the study and passed on their contact information to a research assistant. The research assistant held individual in-person meeting to confirm eligibility and obtain consent, and administered the baseline assessment at a subsequent in-person meeting. Participants were informed about their randomization status at the end of the baseline assessment.

We recruited participants between September 2017 and August 2019, and the BCGP intervention was conducted in waves as follows: four waves at the site in Denver; three waves at the university-based site in Boston; three waves at the outpatient program in Bridgeport; and one wave at the clubhouse in Wakefield, which was added as a site after we exhausted the pool of potential participants at the original study locations. Of the 185 individuals included in the analyses, 82 were recruited at the Denver site, 43—at the Bridgeport site, 34—at the Boston site, and 26—at the Wakefield site. The number of participants per study wave varied between eight and 26. A total of 94 participants were randomized to the experimental BCGP group and 91 to the SAU control group. Participant characteristics at baseline are provided in Table 1. There were no significant differences between the two groups at baseline.

Intervention

The BCGP program builds upon and expands our previously developed "Anti-Stigma Photovoice" program, which successfully incorporated Photovoice research methodology as a therapeutic

Table 1

Baseline Characteristics of Participants in Randomized Controlled Trial (N = 185)

Demographics	Experimental group (*n* = 94)			Control group (*n* = 91)		
	n	%	*M* (*SD*)	*n*	%	*M* (*SD*)
Age			47.39 (11.99)			47.79 (11.62)
Gender						
Male	36	38.3		34	37.4	
Female	57	60.6		56	61.5	
Race						
White	52	55.3		48	52.7	
Black	19	20.2		17	18.7	
Asian	1	1.1		1	1.1	
Pacific Islander	0	0		2	2.2	
American Indian	6	6.4		3	3.3	
Multiracial	16	17.0		20	22.0	
Ethnicity						
Latino/a/Hispanic	18	19.1		18	19.8	
Not Latino/a/Hispanic	76	80.9		73	80.2	
Current marital status						
Single (never married, divorced, widowed)	83	88.3		82	90.1	
Married	11	11.7		9	9.9	
Educational attainment						
Less than high school	12	12.8		12	13.2	
High school/some college	66	70.2		64	70.3	
Bachelors and above	16	17.0		15	16.5	
Psychiatric diagnosis[a]						
Schizophrenia/schizoaffective	23	26.1		19	21.6	
Bi-polar	26	29.6		20	22.7	
Depression	20	22.7		28	31.8	
Posttraumatic stress disorder	7	8.0		8	9.1	
Other	12	13.6		13	14.8	

[a] *n* = 88 for both experimental and control groups due to missing data.

component in a complex stigma reduction intervention (Russinova et al., 2014). The development of the new content was informed by state-of-the art knowledge about community inclusion and was guided by a three-member team of peer experts on peer support services and feedback from peer specialists who have previously delivered our earlier Photovoice-based interventions (Russinova et al., 2014; Russinova, Gidugu, et al., 2018).

The BCGP program was developed as a 6-month manualized peer-delivered intervention with parallel group and individual components. The group component consists of 12 weekly 2-hr sessions, followed by three 2-hr booster sessions delivered a month apart after the 12-week core group curriculum (at the end of Months 4, 5, and 6). Group sessions combine psychoeducational information and exercises about relevant community participation constructs with ongoing goal-setting activities and discussions of pictures and corresponding narratives generated by participants. These elements of the BCGP program have been blended in a unique manner informed by an iterative process of intervention development. Table 2 provides an overview of the BCGP group curriculum. The individual component consists of individual weekly support provided by a designated group leader over the course of the 6-month intervention on an as-needed basis. It parallels the content of the group sessions and is tailored to participants' community participation goals. The BCGP manual includes a Workbook for the participants (Bloch, Legere, Woods, et al., 2021) and a Leader's Guide (Bloch, Legere, Ashcraft, et al., 2021).

The BCGP program is grounded in the psychiatric rehabilitation approach spearheaded by Dr Anthony and his colleagues (Anthony & Farkas, 2009; Anthony et al., 2002; Farkas et al., 2000), which focuses on the process of setting and pursuing meaningful

rehabilitation goals. The goal-setting process embedded in the program is also consistent with the specific, measurable, attainable, relevant, time-bound (SMART) goal-setting approach employed in the broader rehabilitation field (Bovend'Eerdt et al., 2009). We employed the community asset mapping approach (Kramer et al., 2012; Kretzmann & McKnight, 1993; Lightfoot et al., 2014) to educate participants about different types of community and personal assets and to promote awareness about resources specific to their goals. Last, consistent with our prior Photovoice-based interventions (Russinova et al., 2014; Russinova, Gidugu, et al., 2018), we embedded in the program Photovoice methodology to promote awareness about participants' communities and enhance their goal pursuit process.

As part of Photovoice, individuals use cameras to photograph objects or events in their daily lives that are relevant to a given research topic and generate narratives for these pictures through group discussion (Catalani & Minkler, 2010; Strack et al., 2022; Wang & Burris, 1997). The BCGP program includes two Photovoice assignments: "Being a Member of My Community" and "Picturing My Community Goal." As part of the first assignment, participants are encouraged to take pictures and write narratives about their connection to a personally meaningful community, whereas the second assignment asks them to depict the community participation goal they set as part of the BCGP program. The discussion of pictures and writing of narratives is guided by the following prompts informing the acronym "SHOWED": (a) what do you *S*ee here; (b) what is really *H*appening here; (c) how does this relate to *O*ur lives; (d) *W*hy does this problem, concern, or strength exist; (e) how could this image *E*ducate others; and (f) what can we *D*o

Table 2
Bridging Community Gaps Photovoice (BCGP) Intervention—Overview of Group Component Content

Intervention session	Intervention elements
Session 1[c] Overview of the BCGP program	Overview of curriculum and discussion of the concept of community
	Discussion of Photovoice process and review of Photovoice examples
	Exercise: *Creating Our Current Community Map*
Session 2 Community membership	Discussion of community membership and sense of identity
	Discussion of benefits from living in the community
	Exercise: *Enjoyment of Life and Fun Things to Do Activity*
Session 3[c] Learning about photovoice	Discussion of Photovoice process and background
	Discussion of Photovoice ethical and safety guidelines
	Assignment of Photo Mission 1: "*Being a Member of My Community*"
Session 4[c] Development of photovoice narratives	Review of "SHOWED"[a] template as guideline for writing narratives
	Review of pictures from Photo Mission 1
	Writing of narratives for selected pictures
Session 5[c] Setting my community goal	Definition and examples of SMART[b] goals
	Formulation of personal community goals
	Exercise: "*Measuring Progress toward My Community Goal*"
Session 6[c,d] Community asset mapping	Discussion of community resources and mapping resources within community
	Identifying community resources relevant to formulated community goals
	Assignment of Photo Mission 2: "*Picturing My Community Goal*"
Session 7[c,d] Personal asset mapping	Discussion of personal resources, including assets and strengths
	Identifying personal resources relevant to formulated community goals
	Discussion of new pictures and writing of narratives
Session 8[c,d] Prejudice and discrimination as a barrier to community participation	Discussion of prejudice and discrimination manifestations and characteristics
	Discussion of experienced prejudice and discrimination and self-stigma
	Exploring public stigma and self-stigma as barriers to formulated community goals
Session 9[c,d] Other barriers to community participation	Discussion of objective barriers to community participation
	Discussion of subjective barriers to community participation
	Identifying objective and subjective barriers to formulated community goals
Session 10[c,d] Developing my community action toolbox	Discussion of strategies to utilize resources and overcome barriers
	Creating "My Community Action Toolbox" comprised of goal-specific strategies
	Discussion of the relationship between resources, barriers and strategies
Session 11[c,d] My community action plan	Discussion of the "Community Action Plan" as a tool to facilitate goal achievement
	Completing individual "Community Action Plan"
	Review of any new pictures and corresponding narratives
Session 12[c,d] The importance of community participation	Exercise: "*Measuring Progress toward My Community Goal*"
	Discussion of the role of self-determination in community participation
	Exhibit and celebration of completed Photovoice work
Booster Session 1[c,d] Continuing with my community action plan	Discussion of progress toward achieving formulated community goals
	Update of individual "Community Action Plan"
	Review of new pictures and narratives
Booster Session 2[c,d] Continuing with my community action plan	Discussion of progress toward achieving formulated community goals
	Update of individual "Community Action Plan"
	Review of new pictures and narratives
Booster Session 3[c,d] Continuing with my community action plan	Exercise: "*Measuring Progress toward My Community Goal*"
	Exhibit of new completed Photovoice work
	Discussion of perceived benefits and ongoing use of "Community Action Plan"

[a] SHOWED guidelines include the following prompts: (a) What do you see here? (b) What is really happening here? (c) How does this relate to our lives? (d) Why does this problem, concern, or strength exist? (e) How could this image educate others? and (f) what can we do about it?; [b] "SMART" is an acronym that stands for the following goal characteristics: S = specific; M = measurable; A = attainable; R = relevant; T = time-bound. [c] Photovoice process embedded in session. [d] Brief review of participants' progress with community goal attainment at the start of session. BCGP = bridging community gaps photovoice.

about it (Wang & Burris, 1994, 1997). Figures 2 and 3 present examples of Photovoice works created in response to each assignment. Table 2 summarizes the specific ways Photovoice is integrated into each of the BCGP group sessions, whereas the BCGP manual provides detailed description of corresponding content and process (Bloch, Legere, Ashcraft, et al., 2021; Bloch, Legere, Woods, et al., 2021).

The initial draft of the BCGP content and process were piloted and refined based on two development rounds of delivering the program at a university-based rehabilitation program. Afterward, the feasibility and acceptability of the BCGP were tested as part of a small open trial (*n* = 8), which was conducted at the same

university-based rehabilitation program. The open trial included a baseline, 3-month interim, and 6-month posttreatment assessments with all measures used later in the RCT. The first author also conducted exit individual interviews with participants to get additional feedback about their experience with the program. Consequently, the BCGP manual was revised to account for feedback from participants and peer specialists delivering the program as well as live observations of the group sessions by the primary developers of the curriculum.

In the RCT, the BCGP intervention was delivered by teams of 2–3 peer specialists employed at each site. All group BCGP sessions and most individual meetings were delivered in person.

Figure 2

Photovoice Work From Photo Mission 1: "Being a Member of My Community"

Note. *The Veranda*: This is our front porch. Sometimes a group of us will gather there in warmer months. They put extra chairs for people there. We chat and bring out our iced tea or water and popsicles. It's nice to relax and slow down. It reminds me of the old Andy Griffith show when family and friends sit on the porch after supper and talk about things and play guitar and sing. The simplicity of being with others here is restorative; there is a nurturing revitalizing energy that goes around when people talk about their life experience. You start to realize you have more in common than not. You are not alone. See the online article for the color version of this figure.

Weekly team and individual supervision were provided on an ongoing basis.

Measures

We used a standardized instrument (Center for Psychiatric Rehabilitation, 2004) to obtain basic *demographics* (e.g., age, gender, marital status). *Psychiatric diagnoses* were obtained from providers at each study site.

Primary Outcome

Inventory of Community Participation–Mental Health (ICP-MH; Rogers et al., 2021) is a comprehensive measure of both objective and subjective aspects of community participation, integrating two different measurement approaches: (a) 75 legacy items of previously developed measures of community participation using classical test theory and (b) 22 originally developed vignettes assessing community participation based on Rasch measurement principles. The legacy items encompass eight subscales: frequency of community activities, social interactions, sense of community, neighborhood acceptance, reciprocity, participation and opportunities, social supports, and overall satisfaction with community participation (see Table 3, for rating scales and score direction). Two subsets of vignettes assess engagement in community activities and self-efficacy for community participation; each vignette is rated on four ordered response options comparing the respondent's situation with the vignette's main character. Internal consistency for the subscales ranged between 0.82 and 0.87, and for the vignettes—between 0.92 and 0.93 across study assessment points.

Secondary Outcomes

Internalized Stigma of Mental Illness Scale (ISMI; Ritsher et al., 2003) is a widely used 29-item assessing respondents' behaviors, thoughts, and feelings that are self-stigmatizing using five subscales: alienation, stereotype endorsement, discriminatory experiences, social withdrawal, and stigma resistance. Internal consistency ranged between 0.91 and 0.94.

Stigma Scale (King et al., 2007) is a 28-item with three subscales measuring disclosure attitudes as reflective of anticipated stigma,

Figure 3
Photovoice Work From Photo Mission 2: "Picturing My Community Goal"

Note.   Steep Steps: These are the steps you must take to reach your goal. Sometimes the steps may look massive, but each step brings you closer to your goal. The steps at Trinity United Methodist are a steep climb to a reward of a new community waiting at the top. See the online article for the color version of this figure.

experienced discrimination, and positive aspects of living with mental illness. Internal consistency ranged between 0.88 and 0.93.

Approaches to Coping With Stigma (Link et al., 1991, 2002) is a 27-item measuring five strategies to cope with stigma of mental illness: secrecy, withdrawal, educating, challenging, and distancing. Internal consistency ranged between 0.65 and 0.74.

University of California, Los Angeles Loneliness Scale (Version 3; Russell & Cutrona, 1988) is a widely used 20-item measuring loneliness and social isolation. Internal consistency ranged from 0.93 to 0.95.

Behavior and Symptom Identification Scale (BASIS-24; Eisen et al., 2006) is a widely used self-report measure of symptoms and functioning on six subscales: depression/functioning, interpersonal relationships, self-harm, emotional lability, psychotic symptoms, and alcohol/drug use. Internal consistency ranged between 0.90 and 0.91.

Personal Growth and Recovery Scale (PGRS; Russinova et al., 2014) is a 25-item scale measuring perceived recovery and personal growth. Internal consistency ranged between 0.92 and 0.95.

BCGP Fidelity Measure

We measured the content and process fidelity of implementing the BCGP group component using an instrument that incorporated all 13 process items from fidelity scales for other Photovoice-based interventions (Russinova et al., 2014; Russinova, Gidugu, et al., 2018) and new 4–6 content items developed for each BCGP session. All items are assessed on a 4-point scale with mean scores ranging from 1 (*low fidelity*) to 4 (*high fidelity*). Fidelity of individual

Table 3

Outcomes of Study Participants (N = 185) Assigned to the BCGP Experimental Group or to the Services as Usual Control Group

Outcome variable	Group	Baseline (T1) M (SD)	3-month postbaseline (T2) M (SD)	6-month postbaseline (T3) M (SD)	9-month postbaseline (T4) M (SD)	12-month postbaseline (T5) M (SD)	Effect size (Cohen's d)	Group F	Group df	Group p	Time F	Time df	Time p	Group by time F	Group by time df	Group by time p
	BCGP	n = 94	n = 76	n = 71	n = 68	n = 69										
	Control	n = 91	n = 69	n = 56	n = 56	n = 58										
Inventory of community participation																
Frequency of community activities[a]	BCGP	2.47 (0.47)	2.43 (0.49)	2.45 (0.53)	2.34 (0.56)	2.44 (0.52)	0.30	0.14	1,160	.709	6.07	1,160	.015*	5.34	1,160	.022*
	Control	2.37 (0.55)	2.36 (0.56)	2.27 (0.51)	2.22 (0.54)	2.19 (0.47)										
Social interactions[a]	BCGP	2.40 (0.71)	2.65 (0.61)	2.58 (0.68)	2.67 (0.67)	2.71 (0.61)	0.12	0.06	1,160	.815	0.05	1,160	.829	3.77	1,160	.054
	Control	2.54 (0.66)	2.66 (0.68)	2.57 (0.65)	2.49 (0.66)	2.54 (0.70)										
Sense of community[b]	BCGP	3.81 (0.80)	3.96 (0.71)	4.02 (0.67)	4.08 (0.57)	4.07 (0.53)	0.25	0.24	1,158	.622	0.17	1,158	.683	0.89	1,158	.346
	Control	3.75 (0.69)	3.87 (0.74)	3.88 (0.72)	3.87 (0.78)	3.81 (0.72)										
Neighborhood acceptance[b]	BCGP	3.54 (0.67)	3.57 (0.83)	3.58 (0.75)	3.72 (0.74)	3.67 (0.68)	−0.04	0.00	1,160	.999	6.03	1,160	.015	0.24	1,160	.624
	Control	3.48 (0.84)	3.60 (0.74)	3.62 (0.81)	3.69 (0.80)	3.75 (0.73)										
Reciprocity[b]	BCGP	4.31 (0.50)	4.25 (0.53)	4.21 (0.51)	4.21 (0.49)	4.12 (0.43)	−0.06	0.15	1,160	.700	3.63	1,160	.058	0.79	1,160	.377
	Control	4.24 (0.55)	4.29 (0.52)	4.21 (0.54)	4.20 (0.64)	4.22 (0.48)										
Participation and opportunities[b]	BCGP	3.72 (0.70)	3.80 (0.65)	3.76 (0.64)	3.84 (0.62)	3.79 (0.63)	0.13	0.58	1,160	.446	0.00	1,160	.987	1.25	1,160	.265
	Control	3.58 (0.68)	3.72 (0.80)	3.76 (0.76)	3.70 (0.73)	3.66 (0.84)										
Social supports[b]	BCGP	3.89 (0.80)	3.99 (0.66)	4.05 (0.58)	4.01 (0.69)	3.90 (0.68)	−0.08	3.51	1,160	.063	0.29	1,160	.593	2.29	1,160	.131
	Control	3.78 (0.87)	3.88 (0.78)	3.79 (0.80)	3.90 (0.78)	3.86 (0.77)										
Overall satisfaction[c]	BCGP	2.68 (1.18)	2.95 (1.15)	2.93 (1.28)	2.88 (1.27)	3.00 (1.20)	0.04	0.00	1,160	.974	0.01	1,160	.911	0.00	1,160	.995
	Control	2.59 (1.20)	2.91 (1.40)	2.93 (1.17)	2.83 (1.36)	2.90 (1.30)										
Vignettes: Community participation[d]	BCGP	2.98 (0.49)	3.13 (0.47)	3.08 (0.44)	3.14 (0.43)	3.14 (0.48)	0.11	0.52	1,159	.474	0.38	1,159	.541	0.01	1,159	.933
	Control	2.94 (0.49)	3.03 (0.47)	3.09 (0.52)	3.10 (0.49)	3.07 (0.47)										
Engagement in community activities[d]	BCGP	3.05 (0.49)	3.21 (0.49)	3.17 (0.45)	3.24 (0.44)	3.23 (0.50)	0.08	0.56	1,159	.455	0.87	1,159	.352	0.05	1,159	.824
	Control	3.01 (0.52)	3.10 (0.48)	3.20 (0.51)	3.20 (0.48)	3.16 (0.48)										
Self-efficacy for community participation[d]	BCGP	2.88 (0.55)	3.02 (0.50)	2.95 (0.48)	3.00 (0.47)	3.01 (0.51)	0.12	0.41	1,159	.522	0.00	1,159	.998	0.00	1,159	.951
	Control	2.83 (0.49)	2.94 (0.52)	2.92 (0.57)	2.94 (0.54)	2.94 (0.50)										
Internalized Stigma of Mental Illness Scale[e]	BCGP	2.16 (0.39)	2.10 (0.41)	2.01 (0.45)	2.04 (0.42)	2.00 (0.43)	−0.02	1.85	1,160	.176	3.28	1,160	.072	1.25	1,160	.265
	Control	2.13 (0.46)	2.07 (0.45)	2.09 (0.51)	2.00 (0.45)	2.04 (0.49)										
Alienation	BCGP	2.39 (0.58)	2.23 (0.60)	2.19 (0.65)	2.15 (0.58)	2.11 (0.58)	−0.03	5.34	1,161	.022*	8.61	1,161	.004*	0.98	1,161	.323
	Control	2.26 (0.63)	2.25 (0.65)	2.21 (0.64)	2.13 (0.63)	2.15 (0.64)										
Stereotype endorsement	BCGP	1.79 (0.42)	1.79 (0.43)	1.74 (0.46)	1.79 (0.44)	1.76 (0.43)	−0.04	0.08	1,161	.779	0.26	1,161	.614	0.20	1,161	.651
	Control	1.86 (0.51)	1.80 (0.49)	1.82 (0.53)	1.72 (0.45)	1.80 (0.51)										
Discriminatory experiences	BCGP	2.34 (0.55)	2.29 (0.56)	2.15 (0.63)	2.18 (0.55)	2.16 (0.51)	−0.10	1.05	1,161	.307	2.21	1,161	.139	0.87	1,161	.352
	Control	2.33 (0.64)	2.25 (0.57)	2.34 (0.66)	2.21 (0.55)	2.23 (0.62)										
Social withdrawal	BCGP	2.35 (0.61)	2.25 (0.60)	2.14 (0.58)	2.17 (0.58)	2.10 (0.62)	0.05	0.00	1,161	.968	3.37	1,161	.068	0.11	1,161	.737
	Control	2.25 (0.63)	2.15 (0.63)	2.20 (0.73)	2.07 (0.65)	2.14 (0.66)										
Stigma resistance	BCGP	1.98 (0.47)	1.99 (0.45)	1.89 (0.44)	1.96 (0.41)	1.92 (0.43)	0.00	0.42	1,161	.518	0.06	1,161	.804	0.29	1,161	.592
	Control	1.99 (0.47)	1.97 (0.45)	1.94 (0.48)	1.92 (0.45)	1.91 (0.46)										
Stigma Scale[f]																
Disclosure attitudes	BCGP	2.15 (0.71)	2.07 (0.68)	2.06 (0.76)	1.99 (0.72)	2.02 (0.79)	0.00	0.32	1,161	.574	0.56	1,161	.455	0.60	1,161	.440
	Control	2.13 (0.81)	2.01 (0.89)	2.10 (0.90)	2.05 (0.81)	2.01 (0.82)										
Experienced discrimination	BCGP	2.09 (0.71)	2.00 (0.73)	2.00 (0.75)	1.96 (0.76)	1.84 (0.82)	0.01	0.36	1,161	.552	3.75	1,161	.054	0.39	1,161	.535
	Control	2.13 (0.81)	1.92 (0.89)	2.00 (0.88)	1.91 (0.80)	1.93 (0.81)										
Positive aspects of living with mental illness	BCGP	1.39 (0.66)	1.27 (0.51)	1.24 (0.55)	1.25 (0.57)	1.30 (0.61)	−0.10	1.31	1,161	.254	0.00	1,161	.982	0.49	1,161	.483
	Control	1.44 (0.58)	1.34 (0.60)	1.38 (0.67)	1.32 (0.59)	1.26 (0.57)										

(table continues)

Table 3 (*continued*)

Outcome variable	Group	Baseline (T1) M (SD)	3-month postbaseline (T2) M (SD)	6-month postbaseline (T3) M (SD)	9-month postbaseline (T4) M (SD)	12-month postbaseline (T5) M (SD)	Effect size (Cohen's d)	Group F	Group df	Group p	Time F	Time df	Time p	Group by time F	Group by time df	Group by time p
		n = 94 / n = 91	n = 76 / n = 69	n = 71 / n = 56	n = 68 / n = 56	n = 69 / n = 58										
Approaches to Coping with Stigma Scale[g]																
Secrecy	BCGP	2.31 (0.48)	2.27 (0.45)	2.32 (0.51)	2.27 (0.49)	2.22 (0.46)	−0.28	0.06	1,160	.812	0.05	1,160	.825	1.48	1,160	.225
	Control	2.34 (0.51)	2.36 (0.51)	2.45 (0.56)	2.39 (0.50)	2.42 (0.48)										
Withdrawal	BCGP	2.76 (0.34)	2.73 (0.37)	2.72 (0.33)	2.74 (0.38)	2.69 (0.33)	−0.03	0.33	1,160	.567	0.03	1,160	.853	0.81	1,160	.371
	Control	2.78 (0.41)	2.72 (0.36)	2.75 (0.41)	2.70 (0.34)	2.76 (0.36)										
Educating others	BCGP	3.01 (0.52)	2.98 (0.48)	2.93 (0.48)	3.03 (0.48)	2.97 (0.50)	0.00	0.99	1,160	.321	0.04	1,160	.845	0.44	1,160	.507
	Control	2.95 (0.61)	2.98 (0.57)	2.95 (0.56)	3.01 (0.50)	2.98 (0.47)										
Challenging	BCGP	3.04 (0.44)	2.99 (0.43)	2.93 (0.41)	3.03 (0.47)	2.98 (0.50)	0.00	1.11	1,160	.294	1.49	1,160	.224	1.16	1,160	.283
	Control	3.02 (0.46)	3.02 (0.56)	2.94 (0.43)	3.02 (0.46)	2.92 (0.49)										
Distancing	BCGP	2.48 (0.55)	2.42 (0.55)	2.45 (0.59)	2.35 (0.55)	2.32 (0.54)	−0.21	0.57	1,160	.450	0.22	1,160	.641	3.77	1,160	.054
	Control	2.53 (0.59)	2.43 (0.56)	2.55 (0.69)	2.47 (0.57)	2.57 (0.61)										
UCLA Loneliness Scale[h]	BCGP	2.40 (0.58)	2.31 (0.55)	2.31 (0.60)	2.31 (0.58)	2.26 (0.59)	−0.08	0.00	1,160	.958	0.02	1,160	.875	0.07	1,160	.792
	Control	2.46 (0.59)	2.30 (0.62)	2.38 (0.70)	2.33 (0.61)	2.37 (0.60)										
BASIS-24[i]	BCGP	1.42 (0.74)	1.23 (0.64)	1.34 (0.70)	1.25 (0.68)	1.21 (0.62)	−0.10	0.01	1,160	.231	1.95	1,160	.066	0.01	1,160	.596
	Control	1.43 (0.69)	1.36 (0.77)	1.36 (0.71)	1.30 (0.74)	1.31 (0.74)										
Depression/functioning	BCGP	0.29 (0.16)	0.24 (0.14)	0.27 (0.16)	0.25 (0.15)	0.25 (0.15)	−0.19	2.68	1,160	.103	0.89	1,160	.346	1.04	1,160	.310
	Control	0.29 (0.16)	0.28 (0.17)	0.28 (0.16)	0.28 (0.18)	0.26 (0.17)										
Interpersonal relationships	BCGP	0.27 (0.18)	0.27 (0.15)	0.27 (0.17)	0.27 (0.16)	0.25 (0.18)	−0.22	0.24	1,160	.625	1.11	1,160	.294	1.52	1,160	.220
	Control	0.30 (0.17)	0.28 (0.19)	0.31 (0.21)	0.31 (0.22)	0.33 (0.19)										
Self-harm	BCGP	0.17 (0.37)	0.12 (0.35)	0.16 (0.35)	0.14 (0.35)	0.08 (0.22)	−0.06	0.83	1,159	.363	9.37	1,159	.003	0.07	1,159	.792
	Control	0.16 (0.35)	0.19 (0.37)	0.16 (0.32)	0.12 (0.26)	0.14 (0.29)										
Emotional lability	BCGP	0.62 (0.37)	0.52 (0.33)	0.54 (0.33)	0.52 (0.34)	0.52 (0.34)	0.03	0.50	1,160	.482	3.10	1,160	.080	0.40	1,160	.528
	Control	0.61 (0.36)	0.56 (0.37)	0.53 (0.34)	0.47 (0.34)	0.52 (0.35)										
Psychotic symptoms	BCGP	0.22 (0.24)	0.21 (0.25)	0.21 (0.25)	0.20 (0.24)	0.19 (0.24)	−0.08	0.22	1,160	.640	7.08	1,160	.009	0.01	1,160	.924
	Control	0.25 (0.24)	0.24 (0.26)	0.22 (0.23)	0.19 (0.19)	0.22 (0.25)										
Substance abuse	BCGP	0.14 (0.21)	0.11 (0.17)	0.14 (0.21)	0.12 (0.20)	0.12 (0.17)	0.11	0.64	1,160	.423	0.46	1,160	.497	0.18	1,160	.674
	Control	0.12 (0.18)	0.11 (0.17)	0.09 (0.15)	0.10 (0.17)	0.09 (0.16)										
Personal Growth and Recovery Scale[j]	BCGP	3.29 (0.63)	3.39 (0.62)	3.33 (0.61)	3.31 (0.68)	3.40 (0.63)	0.04	0.01	1,157	.913	1.95	1,157	.165	0.01	1,157	.932
	Control	3.26 (0.68)	3.34 (0.71)	3.34 (0.78)	3.27 (0.74)	3.36 (0.73)										

Note. BCGP = bridging community gaps photovoice; BASIS = Behavior and Symptom Identification Scale.
[a] Items are rated on a scale from 1 = *never* to 4 = *often*, where higher scores indicate higher frequency of participation in community activities, or level of social interactions. [b] Items are rated on a scale from 5 = *strongly agree* to 1 = *strongly disagree*, where higher scores indicate higher levels of sense of belonging, feelings of neighborhood acceptance, sense of reciprocity, opportunities for community participation, and social support. [c] Items are rated on a scale from 5 = *excellent* to 1 = *poor*, where higher scores indicate greater satisfaction with social activities and relationships. [d] Items are rated on a scale from 4 = *better than* to 1 = *worse than*, where higher scores indicate a "better situation" as compared to the main character of each vignette. [e] Items are rated on a scale from 1 = *strongly disagree* to 4 = *strongly agree*, where higher scores indicate higher levels of perceived and anticipated stigma and lower positive aspects of living with mental illness. [g] Items are rated on a scale of 0 = *strongly agree* to 4 = *strongly disagree*, where higher scores indicate higher likelihood of strategy use. [h] Items are rated on a scale 1 = *never* to 4 = *always*, where higher scores indicate higher level of loneliness. [i] Items are rated on a scale of 0 = *no difficulty* to 4 = *extreme difficulty*, where higher scores indicate higher level of difficulty or severity of symptoms. [j] Items are rated on a scale from 1 = *disagree* to 4 = *agree*, where higher scores indicate a higher level of perceived personal growth and recovery.
* $p < .05$.

support meetings was monitored as part of peer leaders' weekly supervision.

Data Collection Procedure

All instruments, except for demographics, were administered at all assessment points of the RCT. Demographics were obtained only at baseline. Research assistants administered postbaseline assessments in-person and, on rare occasions, by phone. The last two assessments for the last study wave at the Denver site were conducted by phone due to COVID-19 restrictions.

All participants in the experimental group were invited to provide feedback about their experience with the BCGP program after completion of their final assessment. Research staff at each study site led in-person exit focus groups at the end of each RCT wave. Only the last focus group at the Denver site was held remotely due to COVID-19 restrictions. All focus groups were recorded and transcribed.

Data Analyses

Statistical Analyses

Descriptive statistics were computed to summarize participant characteristics, program participation, and means and standard deviations for outcomes at each time point of the study. T tests and chi-square analyses were conducted to compare participants in the experimental and control groups on baseline characteristics. Intent-to-treat analyses using mixed effects regression models were conducted to evaluate the impact of the BCGP program on the following outcomes: (a) for Hypothesis 1—community participation dimensions and (b) for Hypothesis 2—internalized, experienced and anticipated stigma, strategies to cope with stigma, loneliness, psychosocial functioning, and personal growth and recovery. We used PROC MIXED in SAS 9.4 to test for time and group differences in scores. All postbaseline assessment scores were the repeated dependent measures, whereas the baseline score was included as an independent variable in the model. A random intercept was used to account for clustering of observations within individuals. Group, time, and interaction of group and time were included as independent variables in the analyses. We did not use a correction for multitesting given the exploratory nature of this first study testing the effectiveness of the BCGP program.

We also conducted secondary analyses examining the effect of exposure to the BCGP intervention (as measured by number of group sessions attended) on outcomes. We replaced the group variable by the exposure variable for which participants in the control group were assigned zeroes.

We assessed the fidelity of the group BCGP sessions, calculating the average means for content and for process fidelity for each study site. Fidelity was assessed by the last author based on audio recordings of the group sessions.

Qualitative Data Analysis

We analyzed the transcripts of the exit focus groups with participants in the BCGP program ($n = 24$) using a thematic analysis approach (Javadi & Zarea, 2016; Miles et al., 2019). We used a deductive approach to identify the thematic domains representing the perceived active ingredients of the BCGP program and the mechanisms of their beneficial impact, and an inductive approach to identify the specific categories pertinent to each of these two domains. New categories were initially identified by the first author and finalized following review by the remaining authors.

Results

Nineteen (10%) of the 185 participants did not complete any postbaseline assessments. The majority of participants ($n = 13$, 68%) who dropped out were from the control group. Participants in the BCGP program attended on average 6.02 of the 12 weekly group sessions, 0.94 of the three booster sessions, and 5.79 of the individual sessions. Utilization of individual sessions was on average 4.53 during the first 3 months of the BCGP program and 1.66 during the next 3 months. Five participants (5%) did not attend any BCGP sessions. The average scores for BCGP content fidelity ranged between 3.83 and 3.93, and for process fidelity, between 3.85 and 3.97, across study sites.

Hypothesis 1—Community Participation as a Primary Outcome

Contrary to our hypothesis, intent-to-treat analyses (Table 3) revealed only a significant group-by-time interaction in the frequency of community activities as measured on the corresponding subscale of the ICP-MH measure, which favored participants in the BCGP program. More specifically, they maintained a stable level of community participation over the course of the study while there was a trend of decline among the participants in the control group, which was most noticeable at the 12-month assessment. A group-by-time interaction for the Social Interactions subscale of the ICP-MH was trending toward significance favoring the experimental group over time, with a more noticeable difference between the two groups also at the 12-month assessment point.

Secondary analyses accounting for exposure to the intervention revealed that greater attendance of BCGP group sessions had a significant positive impact on community participation as measured on the Frequency of Community Activities subscale of the ICP-MH ($F = 6.67$, $df = 84$, $p = .011$). In addition, greater attendance was associated with significantly higher level of community participation based on the total score for the ICP-MH vignettes ($F = 4.18$, $df = 83$, $p = .044$), and with significantly greater self-efficacy for community participation ($F = 5.76$, $df = 83$, $p = .019$) as measured by the corresponding vignettes subscale of the ICP-MH.

Hypothesis 2—Psychosocial Functioning Constructs as Secondary Outcomes

The BCGP program had a significant positive impact on one dimension of internalized stigma: When compared to the control group, the experimental group experienced a significantly lower sense of alienation as measured by the Alienation subscale of the ISMI scale (Table 3). Also, the impact of the BCGP program on one strategy of dealing with psychiatric stigma was trending toward significance, namely, the experimental group experienced a reduction over time in distancing themselves from others as measured by the Distancing subscale of the Approaches to Coping with Stigma measure, whereas the control group did not change. Participation

in the BCGP program did not have a significant impact on the proactive coping subscales (educating and challenging other) of the Approaches to Coping with Stigma measure, on experienced and anticipated stigma as measured on the Stigma Scale, on loneliness, psychosocial functioning and personal growth and recovery. Last, exposure to the BCGP program did not have a significant impact on any of the hypothesized secondary outcomes.

Qualitative Substudy

Participants reported that the BCGP program had a positive impact on their community participation as it expanded their understanding of community, gave them new skills, and motivated them to pursue personally meaningful goals. One individual explained,

> What I liked about the class is that it gave me a new way to focus and a new way to accomplish goals because a lot of times I would start projects and not really be able to finish them

whereas another stated "it just opened a whole new world to me" and help "put my foot out there and just do it."

Participants identified two components of the BCGP program as being particularly helpful: the goal-setting process and the Photovoice process. They also described specific beneficial aspects of each component and corresponding mechanisms of impact on community activities.

Goal Setting and Attainment Process

In addition to being guided to set SMART goals, participants stated that learning how to break their community participation goals into smaller steps was critical to their success. One individual described this process as "deconstructing the goal into a step-by-step process" and another elaborated:

> I learned how I could look at those concrete steps and actually going through them one by one and not skipping over them. Just really going very methodically through them gave me a tool that I can use. That I can take with me . . . I have had a lot of times when I was not able to reach my goal or to work methodically on my goal or to make progress. I was just kind of treading water and trying to keep the status quo . . . This class help[ed] by creating in this very methodical way the path to achieving a goal.

Participants identified a wide range of benefits that resulted from this process and facilitated the accomplishments of their goals: (a) increased awareness about specific goal steps; (b) helped stay focused on one step at a time; (c) created a framework for a continuous and consistent goal pursuit; (d) helped develop skills to break goals into steps; (e) increased confidence in one's capacity to manage goal elements; and (f) provided a sense of accomplishment when each step is achieved.

Participants also found linking each goal step to specific barriers and individual and community resources helpful. They felt that this process helped them organize their thinking and stay on track with the pursuit of each step of their goal, as it created a sense of preparedness about what was coming next. One person pointed out:

> That helps—just writing down what the barriers and the resources—or just coming up with the roadblocks. Because we know what the roadblocks are. But we don't necessarily actively know it. It is not in our active consciousness when we kind of go about something. But

then when we set it down in a structured form and we say, hey, these are the things that I may run into, and here are things that I can rely on and fall back on. It makes the actual thing that you are trying to do easier because you are prepared beforehand.

Last, participants found the review of goal progress at the beginning of each group session helpful. They expressed that they were able to learn from other people's experience in pursuing their goals and understand how to be flexible with goal setting, including prioritizing among multiple goals. At the same time, this process increased their sense of accountability to the group and helped them make progress on their goals.

Photovoice Process

Participants reported liking the Photovoice component of the BCGP program, including taking pictures and feeling like everybody else in the community. They felt that this process increased awareness of and sense of connection to their local communities, brought more clarity about their goals, increased motivation to connect with others in the community, and fostered their creativity. One participant explained:

> My first picture was like I am alone on New Year's. But writing up that summary of it made me feel more like trying to interact with other people and trying to get involved and trying to do things . . . It created the desire to connect more with others, a greater likelihood that I actually would.

Discussion

This study provided initial evidence about the promise of the BCGP program in promoting the community participation of individuals with psychiatric disabilities. Consistent with the rights-based perspective about community inclusion of people with disabilities (Salzer, 2021), we have operationalized community participation as the process of recognizing and utilizing existing opportunities for meaningful community involvement as well as creating new opportunities to foster one's well-being and personal growth. Thus, the BCGP program focused on increasing the self-efficacy of individuals with psychiatric disabilities to enrich their lives through involvement in a broad spectrum of personally meaningful community activities.

Both intent-to-treat and secondary analyses revealed the initial promise of the BCGP program to impact positively the most critical aspect of community participation: involvement in meaningful activities in the community. More specifically, the program contributed to a greater consistency in the amount of community activities pursued by participants over the course of the study, given fluctuations in the frequency of community activities among participants in the control group. To the best of our knowledge, this is the first report about the significant impact of an intervention on the objective aspects of community participation of individuals with psychiatric disabilities. While this is an important finding, the limited magnitude of positive changes (i.e., stability vs. greater frequency of activities) suggests that further efforts to enhance the intensity of the BCGP program may be necessary. Given the very limited impact of previously developed social inclusion programs (i.e., Davidson et al., 2004; Sheridan et al., 2015), our study findings further highlight the difficulties the field of psychiatric rehabilitation has faced in developing effective interventions to increase the community participation of

people with psychiatric disabilities. It may be helpful to establish a national taskforce involving a broad spectrum of relevant stakeholders in order to shed light on underlying challenges and innovative ways to address them.

Secondary analyses which revealed the significant impact of attendance of BCGP group sessions on self-efficacy for community participation and on the frequency of community activities identify another area for future enhancement of the BCGP program. It will be important to explore additional strategies to enhance engagement in the program, especially given the critical role of self-efficacy in initiating and sustaining personally meaningful community involvement. It may be particularly useful to rethink the open-ended process of the BCGP individual support meetings and consider a more structured approach to their content and implementation.

Contrary to our expectations, the BCGP program had a minimal impact on the hypothesized secondary outcomes. We were particularly surprised by its very limited effect on personal stigma, given the promise of our previously developed stigma reduction program (Russinova et al., 2014), which informed the BCGP development. More specifically, participation in the BCGP program was associated with a significant decrease in only one of the facets of internalized stigma, namely, the sense of alienation from other members of the community. There was also tentative evidence that participants may be less likely to distance themselves from other community members to shield themselves from public prejudice and discrimination; however, there was no significant change in their use of proactive strategies to cope with public stigma, such as educating and confronting others who exhibit prejudicial attitudes and behaviors. This finding may be explained by the fact that the peer experts who guided the development of the BCGP program felt strongly that previously developed stigma reduction content needs to be presented in a very succinct way and embedded in an overall positive context focusing on the pursuit of community participation goals. However, study findings about the very limited impact of the intervention on personal stigma suggest that it may be helpful if participation in the BCGP program is preceded by involvement with effective stigma reduction interventions (i.e., Lucksted et al., 2017; Russinova et al., 2014; Yanos et al., 2019) that would strengthen individuals' capacity to cope proactively with encounters of prejudice and discrimination in the communities of their choice. It was also surprising that the BCGP program did not influence in a meaningful way participants' sense of loneliness, psychosocial functioning, and perceived recovery. Future research may shed more light on these findings as well as identify additional ways to strengthen the BCGP program.

At the same time, our qualitative substudy painted a richer picture about the perceived value of the BCGP program. Participants' reports corroborated quantitative findings about its positive impact on their self-efficacy to pursue community involvement; however, they also revealed other benefits (i.e., motivation for community involvement, goal-setting skills, etc.) that were not captured by our standardized measures. While the qualitative substudy involved participants who were interested in sharing feedback about the program, the discrepancy between quantitative and qualitative findings is a reminder of Dr. Anthony and colleagues' (Anthony et al., 2003; Farkas & Anthony, 2006) argument about a more balanced approach toward evidence-based and value-based practices grounded in recovery principles. The importance of value-based practices reflective of the perceived benefits to individuals and organizations is highlighted by the fact that the large mental health center that served as the study site in Denver initiated agency-wide implementation of the BCGP program prior to the completion of the randomized study (Bylander, 2021). Future research may also explore the relevance of the BCGP intervention to mental health programs and services that may inherently enhance engagement and participation in the program. For example, it may be interesting to develop and test an adaptation of the BCGP program to be delivered at residential programs serving individuals with the most disabling mental health challenges.

Our qualitative substudy also generated initial information about the active components of the BCGP intervention. While it reinforced the importance of the Photovoice process as contributing to participants' engagement and group cohesion, it highlighted the critical value of the goal-setting component embedded in the program. Future research employing an intervention dismantling design can provide evidence about the effectiveness of its different components and optimize its implementation.

Study findings need to be examined in light of several limitations. First, study findings need to be considered with caution given the number of statistical tests conducted. Given the exploratory nature of this first randomized trial, we decided to explore a wider range of possible outcomes. In addition, the number of tests was influenced by the high number of subscales for most of our measures. Future studies evaluating the program's effectiveness may consider a more focused selection of outcome measures and correction for multitesting. Second, a longer follow-up period may be needed to account for the program's impact on loneliness and psychosocial functioning. Third, program attendance was lower than expected, especially attendance of individual meetings following the 12-week core group component. It is useful to consider additional engagement strategies in future studies or practice implementation. Fourth, the small size of some study waves may have contributed to diminished attendance of BCGP sessions.

Conclusions

Supporting people with psychiatric disabilities to have meaningful and rich lives and feel like equal members of their communities is the next frontier to be conquered by recovery-oriented service systems. This study demonstrated the potential for the BCGP intervention to contribute to this outcome through the enhancement of self-efficacy for community participation. Future research can provide further evidence about its effectiveness and inform wider implementation in community mental health programs.

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