Consumer Practitioners in PATH-Funded Programs

REPORT OF THE

CONSUMER INVOLVEMENT WORKGROUP

This report represents the results of the non-Federal workgroup's findings. All views expressed are those of the workgroup members and do not represent the official position of any government agency or other organization.

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Introduction

Each State or Territory that receives Projects for Assistance in Transition from Homelessness (PATH) funds has a State PATH Contact who provides oversight to the program's local implementation. Among other activities, State PATH Contacts identify topics that are of special interest to the PATH program and select workgroups to study these topics in depth. In early 2003, the PATH Consumer Involvement Workgroup, under the leadership of Charles Bliss of Georgia's Division of Mental Health, Mental Retardation and Addictive Diseases, began meeting to gather and develop:

- Data and information on what States are currently doing to employ consumers in PATH programs
- A description of PATH programs that are considered exemplary in this regard
- An examination of issues related to consumer employment, including advantages, challenges, and strategies
- Recommendations for employing mental health consumers in PATH programs

The PATH Consumer Involvement Workgroup's guiding vision was to encourage PATH programs to employ mental health consumers with homelessness experience as direct care staff. To accomplish this goal, the workgroup conducted the following activities:

- Conducted a survey of State PATH Contacts to collect information on the States' practices regarding employment of mental health consumers in PATH-funded programs.[1] A total of 41 States responded (82 percent of those surveyed). The survey is included in Appendix A. Results of the survey are featured in the next section.

- Identified eight States, from among the 41 respondents, as being particularly active in employing mental health consumers with homelessness backgrounds in their PATH programs. The eight States are California, Florida, Georgia, Illinois, Louisiana, New Jersey, Ohio, and Oregon.

- Created a set of *Criteria for Exemplary Programs* (see Appendix B) to identify PATH-funded programs that are considered exceptional in hiring, training, and supporting consumer practitioners.

- Used the established criteria to secure nominations for PATH-funded and non-PATH-funded exemplary programs from all States. Thirteen States nominated 15 programs.

[1] Surveys were developed by workgroup members for use in gathering information from their colleagues. All inquiries about activities of the workgroup should be directed to Charles Bliss in Georgia, cbliss@dhr.state.ga.us.

- Asked all nominees to complete an administrator/supervisor version and a consumer practitioner version of a more detailed survey (Appendices C and D). Survey questions focused on advantages, challenges, strategies, and recommendations for employing consumers in PATH-funded programs.

- Reviewed these responses and reached consensus on the four programs that could be considered exemplary. See program descriptions in Appendix E.

- Conducted qualitative interviews with administrators/supervisors and consumer practitioners from the four exemplary programs.

- Held monthly teleconference meetings that included the participation of consumers and invited guests (representatives of Federal and State agencies, consumer-run organizations, advocacy groups, and human service providers).

This report represents the results of the workgroup's findings. All views expressed are those of the workgroup members and do not represent the official position of any government agency or other organization. Readers are encouraged to contact the exemplary programs for further details and to consult the extensive list of resources at the end of the report. Members of the PATH Consumer Involvement Workgroup are listed in Appendix F.

A Word about Terminology

As Van Tosh (1993) noted, there are a number of terms used to identify people who use or have used mental health services. For purposes of clarity, this report will use the term "consumer practitioner" to refer to individuals with a history of mental illness and/or homelessness who are in paid or volunteer positions in PATH-funded programs. The individuals they serve will be identified as "service recipients," "clients," or "peers."

Background

The President's New Freedom Commission on Mental Health called for nothing short of *fundamental transformation* of the mental health care delivery system in the United States—from one dictated by outmoded bureaucratic and financial incentives to one driven by consumer and family needs that focuses on building resilience and facilitating recovery. Recovery is at the heart of mental health transformation, with consumers at the *center* of the system of care. The Commission called for consumers to be involved in planning, delivering, and evaluating mental health services (New Freedom Commission, 2003).

Many factors have contributed to the evolution of consumer participation in delivering services to people with serious mental illnesses and people who experience homelessness. These include the growth of the mental health self-help movement, the Federal Center for Mental Health Services (CMHS) Community Support Program, and the development of person-oriented policies for people with mental illnesses at the Federal level (Van Tosh, 1993). In addition, Mowbray (1997) pointed out that the movement toward consumer involvement in mental health service provision is grounded in the larger society's endorsement of consumerism and self-help in general, and in legal battles establishing human rights policies for disenfranchised groups, especially people with disabilities.

Prior to the New Freedom Commission report, several influential groups lent their support to these efforts. In a 1989 policy statement, the National Association of State Mental Health Program Directors noted that "mental health consumers have a unique contribution to make to the improvement of the quality of mental health services in many arenas of the service delivery system" (NASMHPD, 1989). Several years later, the Federal Task Force on Homelessness and Severe Mental Illness (1992) called for the involvement of consumers in planning, delivering, monitoring, and evaluating services for people with mental illnesses who experience homelessness. Today, programs that receive PATH funds are expected to have a track record of involving mental health consumers and their family members in all aspects of program planning, governance, staffing, and evaluation.

A Framework for Consumer Involvement

Mental health consumers and individuals who have been homeless have a variety of roles in PATH-funded programs. For example, they may serve on consumer advisory boards or evaluate satisfaction with services. Provision of direct services may encompass a variety of activities, including outreach, housing referral, case management, counseling, crisis prevention, or staffing a drop-in center (Van Tosh, 1993).

Mowbray and Moxley (1997a) developed a framework for consumer involvement in psychiatric rehabilitation based on two key dimensions: whether or not consumers control the alternative (control) and whether the primary aim of the alternative is mutual support or service provision (aim). This results in a four-quadrant model, represented by the following groups (see Table 1), which acknowledges the diversity of roles consumers play:

1. *Self-help programs* controlled by consumers, where the aim is mutual support (versus formal service provision)
2. *Consumer-run services* also controlled by consumers, but with the aim of service provision
3. *Consumers as employees* working in non-consumer-controlled mental health or psychosocial programs, whose aim is formal service provision
4. *Consumer-initiated services* whose aims are mutual support, but which operate within traditional services (not consumer-controlled)

Table 1: Consumer Roles in the Provision of Services or Supports

		CONTROL OF THE ALTERNATIVE	
		Consumer	**Non-consumer**
AIM OF THE ALTERNATIVE	**Service Provision**	**I. Consumer-Run Services**	**II. Consumers as Employees**
	Mutual Support	**III. Self-Help**	**IV. Consumer Initiatives**

Source: Mowbray & Moxley, 1997a.

The most common consumer-run services are drop-in centers, which provide a sense of community, camaraderie, and welcome to people with serious mental illnesses, including those who experience homelessness (Mowbray & Moxley, 1997a). Typically, consumers control the boards of these agencies and they may contract with the formal mental health system to provide services. Preliminary results of a multi-site evaluation of eight consumer-operated service programs revealed that consumer-operated programs were rated more highly than traditional mental health services. Further, individuals who attended consumer-operated programs reported a greater sense of well-being (Campbell, 2005).

The aim of self-help groups and consumer-initiated services is mutual support, which is designed to enhance formal services through peer support and social networks. The balance of this report focuses on consumer involvement in service provision in PATH-funded agencies.

Support from Research

Though the research literature on the involvement of consumers as service providers is not extensive, several researchers have found that consumers provide services equal to those of non-consumers (Chinman et al., 2000; Lyons et al., 1996; Solomon & Draine, 1994, 1995). In particular, Chinman and colleagues, comparing consumer and non-consumer provided case management services for people with serious mental illnesses who experience homelessness, concluded, “Treatment by consumer providers is not associated with *superior* client outcomes.

However, it is notable that treatment by consumer providers is associated with *equivalent* outcomes (Chinman et al., 2000; emphasis original). The investigators went on to note that because clients served by consumers were more depressed, more psychotic, and spent more days homeless than those served by non-consumers, "the equivalence in outcomes between the consumer and non-consumer case managers was even more impressive."

Lyons et al. (1996), examining service delivery using consumer staff in a mobile crisis assessment program for people with serious mental illnesses who experience homelessness, found that consumer staff engaged in more street outreach and were less often likely to certify their clients for psychiatric hospitalization. Solomon and Draine (1995) reported no difference in clinical or quality of life outcomes of clients with serious mental illnesses served by a consumer case management team compared to a team of non-consumer case managers. The researchers concluded, "In the case of consumer delivered services in public mental health, a finding that consumers are as effective in delivering services as non-consumers who are not mentally ill has significant implications for the design of new services."

In addition to case management and outreach, consumers offer peer support services that "provide an opportunity for people with mental illnesses to direct their own recovery and advocacy process, and to teach others the skills necessary to lead meaningful lives in the community" (www.nmha.org/pbedu/adult/peerSupport.cfm). Peer specialists are becoming an important adjunct to professionally delivered services in many programs that serve people with serious mental illnesses, including those who are homeless. Researchers have found that when peer specialists are integrated into a case management team, it leads to enhanced quality of life for clients and more effective case management (Felton et al., 1995).

Georgia was the first State to make peer specialist services reimbursable under the Medicaid rehab option and other States have followed suit, including Arizona, Iowa, Michigan, and Washington; Pennsylvania expects it peer specialist services to be Medicaid-reimbursable beginning in October 2006. SAMHSA is nearing completion of a resource kit designed to help States establish Medicaid-funded peer support services and a trained workforce of peers. When the kit—which will include a manual with detailed information on how to design, plan, implement, and manage a peer specialist program—is complete, it will be sent to mental health commissioners and advocates in each State. In addition, the Mental Health Association of Southeastern Pennsylvania (MHASP) spearheaded creation of a new national trade association—the National Alliance of Peer Specialists.

For more information on peer specialists, see the following resources:

- Information on Georgia's Peer Specialist Program at http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD
- A description of peer support services in South Carolina at www.state.sc.us/dmh/best_practices/peer_support.html
- Details on a peer specialist training program offered by the MHASP Institute for Recovery and Community Integration at www.mhrecovery.org

Survey of Consumer Involvement in PATH Programs

Nationally, only about one in three people with mental illnesses is employed (New Freedom Commission, 2003). PATH programs provide an important venue for consumer employment and, consequently, recovery.

The Consumer Involvement Workgroup conducted a survey of State PATH Contacts to collect information on State practices regarding employment of mental health consumers in PATH-funded programs. A total of 41 States responded (82 percent of those surveyed). The 41 States reported on 378 PATH-funded local providers. The survey is included in Appendix A. Highlights of the survey results follow.

Paid employment (paid minimum wage or higher)

Table 2 presents the percentage of respondents using employed mental health consumers by type of service provided.

Table 2: Percentage of Respondents Using *Employed* Mental Health Consumers by Service Type

Service Type	Percent
Outreach services	85%
Referrals for other services	62%
Case management services	58%
Supportive & supervisory services in residential setting	50%
Habilitation & rehabilitation services	35%
Community mental health services	35%
Staff training	35%
Screening & diagnostic treatment services	19%
Alcohol or drug treatment services	19%

Highlights:

- 63 percent of the States reported having at least one agency that employs consumers as staff in PATH programs.
- At the agency level, 25 percent reported employing at least one consumer.
- 136 paid consumer staff, representing 93.55 full-time equivalents (FTEs), are employed by the 93 agencies that reported employing at least one consumer.
- Outreach was the most common service that consumer employees delivered, followed by referrals for other services and case management services (see Table 2).
- Approximately 64 percent of the paid/employed mental health consumers have experienced homelessness.

Volunteer work (paid less than minimum wage)

Table 3 presents the percentage of respondents using mental health consumers in positions that paid less than minimum wage.

Table 3: Percentage of Respondents Using Mental Health Consumers as *Volunteers* to Deliver Service(s) by Service Type

Service Type	Percent
Outreach services	60%
Referrals for other services	40%
Case management services	27%
Supportive & supervisory services in residential setting	27%
Habilitation & rehabilitation services	20%
Community mental health services	20%
Staff training	13%
Screening & diagnostic treatment services	7%
Alcohol or drug treatment services	7%

Highlights:

- 37 percent of States reported having at least one program that uses mental health consumers as volunteers to deliver PATH services.
- At the agency level, 4 percent reported having mental health consumers as volunteers.
- As with those consumers who are paid, outreach was the most common service that consumers delivered as volunteers, followed by referrals for other services and case management services (see Table 3).

Additional consumer involvement

- States reported that 63 percent of programs use consumer satisfaction surveys to receive feedback about their programs.
- In addition to conducting consumer satisfaction surveys, programs use a range of strategies to gain consumer input:

- Participation on governing bodies, advisory boards, steering committees, and planning councils
- Community meetings, forums
- Consumer and family interviews, including discharge/exit interviews
- Focus groups
- Individual needs assessments and feedback
- Suggestion boxes
- Feedback from other providers

Advantages of Employing Consumer Practitioners

In the preface to *Working for a Change* (Van Tosh, 1993), Dr. Anthony F. Lehman asks and then answers a question that may be on the minds of many agency administrators who are considering hiring consumer practitioners:

> *Is it simply a politically correct idea that gains points with funding agencies? No. The fact is that when implemented correctly, [the] involvement [of consumer practitioners] greatly enhances the quality of services that patients receive. It's as simple as that; it improves care!*

Both the literature and the in-depth interviews with PATH administrators and consumer practitioners are replete with the many advantages of hiring people with mental illnesses who have experienced homelessness to engage their peers into treatment and services. Advantages accrue to the recipients of services, to the consumer practitioners themselves, and to the PATH-funded agencies they serve. For ease of discussion, these categories are presented separately, even though, in reality, they overlap. For example, when the presence of consumer staff increases an agency's awareness of the capabilities of people with psychiatric disabilities, services may become more relevant and attractive to clients (Besio & Mahler, 1993). Both the agency and its clients benefit.

Advantages for Service Recipients

Especially for clients who have had previous negative experience in the service system, the use of consumer practitioners might mean the difference between getting off the streets and recovery or remaining homeless and symptomatic (Glasser, 1999). Consumer practitioners have unique characteristics that enhance their ability to provide services to individuals who experience homelessness (Van Tosh, 1993). They include those noted below.

Increased empathy and understanding

Consumer practitioners who have experienced similar situations as the people they serve can offer empathy and true understanding and often are better able to earn the trust of their peers. This increases the chance of success and satisfaction for the program's participants. One PATH consumer practitioner explained that "having been there makes a big difference. I have learned an awful lot that I am able to bring into the job that I'm sure somebody who hasn't gone through what I have would know." Another suggested that "it gives more credibility with the people we serve because I have been there…it creates maybe a little bit of a bond."

A non-judgmental approach

Consumer practitioners may be more tolerant of unusual behaviors and are less likely than non-consumer staff to feel the need to maintain a professional distance (Besio & Mahler, 1993). Interview respondents commented that consumer practitioners understand that the process of change and recovery is gradual and takes time. The consumer practitioners' experience of "being there" can provide a sensitivity that allows them to take a non-judgmental stance when it comes

to going above and beyond to help someone or just demonstrating kindness. One consumer practitioner noted, "Yeah, I fell off the wagon, so I know that's the time to start all over again." When asked if this is enabling people to continue to live out on the street by rescuing them, one respondent said, "Well, I would say this, if it ever happens to you, you would probably hope and pray you run across somebody like me."

An increased focus on self-reliance

Consumer practitioners tend to encourage independence and hold clients to a high standard, PATH respondents said. Conversely, consumer practitioners are more likely to discourage their peers from languishing in the system.

A living model of recovery

Consumer practitioners can be effective at promoting a message of hope and recovery. One consumer practitioner explained, "I work with a couple of people who have social anxiety. I also have social anxiety, and I've learned to overcome it, which helps [the people with whom I work] understand that they can overcome it, too. I couldn't even ride a bus 3 years ago, and now I'm teaching people to ride buses. And that inspires them." Another offered, "People use us as role models, because we are living testimony to the fact that the program works."

Flexibility and patience

Consumer practitioners may not view "compliance" with any or all services to be a requirement to receive other available services. In this regard, they exhibit a sense of flexibility and patience that is frequently needed in providing time-intensive services to people with serious mental illnesses who experience homelessness (Van Tosh, 1993).

Engagement/peer support

Frequently, workers know people who experience homelessness and they can easily establish rapport that is critical to the engagement process. Part of this rapport is a shared understanding of what it means to be homeless and the resulting anger, frustration, and feelings of despair (Glasser, 1999; Van Tosh, 1993). Mutual support can be an important coping strategy for both clients and consumer practitioners.

Familiarity with practical resources

Consumer practitioners may be more aware of supports and services available in the agency and in the community. They understand the necessity of meeting a client's basic survival needs (e.g., food, shelter, showers, etc.) (Van Tosh, 1993), and they know how to overcome obstacles to obtaining needed resources (Besio & Mahler, 1993). One PATH administrator commented that consumer practitioners' "familiarity with the organization and the various programs [allow them] to more quickly link our clients with the programs that run internally." It saves time and expedites services when policies, procedures, and programs are familiar.

Fighting stigma and discrimination

Consumer practitioners can be a major force in the elimination of stigma and discrimination against people with serious mental illnesses and people who experience homelessness. Research reveals that facilitating contact between people who have mental illnesses and other groups helps reduce prejudicial attitudes (Watson & Corrigan, n.d.). This is critical because in its most virulent form, stigma "can impact the development of housing opportunities and other services required to end homelessness" (Van Tosh, 1993). Stigma also may negatively impact a person's willingness to seek help for mental health problems.

Advantages for Consumer Practitioners

Consumer practitioners working as mental health providers experience both personal and professional growth (Mowbray, Moxley, & Collins, 1998). Specific benefits include increased self-esteem, acquisition of vocational skills, and higher income (Besio & Mahler, 1993). In particular, people who are able to help others experience a heightened sense of self-worth themselves. This effect is known in the consumer/survivor community as the "helper's principle" (Van Tosh & del Vecchio, 2000).

Perhaps most important, consumer practitioners have experiences associated with recovery, including participation in meaningful activities, valued roles, a structured day, and opportunities for training and work (Mowbray, 1997). In particular, as PATH respondents noted, meaningful employment contributes to overall well-being and represents recovery for many consumer practitioners as well as for their peers in treatment. Employment and inclusion can be a transformative experience, especially when the consumer practitioner is empowered to facilitate that process for a peer. Consumer practitioners are motivated to stay well and to inspire others to achieve and share a sense of well-being and competence in their lives.

One consumer practitioner noted, "Your job can keep you well. If you lay in bed all day, you just keep getting sicker and sicker. You don't care about life. When I got up out of bed and went to work, I started feeling so much better about myself."

Advantages for PATH Programs

Consumer practitioners are dedicated, committed, and reliable, PATH respondents said. The level of commitment by consumer practitioners speaks to their deeper understanding of the need sometimes to transcend traditional work hours and responsibilities in order to help people struggling with mental illnesses and homelessness. They are willing to do more than what is routinely expected and to be flexible in their hours and tasks (Besio & Mahler, 1993).

In addition, hiring consumers as practitioners helps the organization be consumer-focused. Consumer practitioners in administrative or decision-making positions are influential in creating, supporting, and enforcing a peer model that supports individual and agency-wide transformation, PATH respondents said.

Further, several observers point out that employing consumers as staff can increase the sensitivity of non-consumer staff to both the challenges their clients face and the skills and strengths they possess, thereby increasing the responsiveness of services (Glasser, 1999; Dixon, Krauss, & Lehman, 1994). Finally, the use of consumer practitioners can effect organizational change toward a model of non-hierarchical, collaborative services (Mowbray, 1997).

Challenges to the Use of Consumer Practitioners

The concept of employing consumer practitioners is simple, but the implementation may be complex (Van Tosh, 1993). Indeed, in the preface to *Working for a Change,* Dr. Anthony F. Lehman notes, "The very prospect [of employing consumer practitioners] sets off all kinds of cautionary bells regarding confidentiality, safety, professionalism, competence, and control" (Van Tosh, 1993). Despite the numerous benefits to the use of consumer practitioners, there are significant challenges for clients, for consumer practitioners themselves, and for the PATH-funded agencies they serve. Many of these challenges are outlined below, along with strategies PATH programs use to address them.

Challenges for Service Recipients

Though the use of consumer practitioners is believed to close the distance between clients and staff, some program clients may chose only to have services delivered by "qualified," professional staff, Mowbray (1997) reported. In addition, they may feel they can't trust a consumer who is no longer "one of us." The potential blurring of boundaries between friendship and assistance, as noted in the section below, may be confusing for a program's clients.

Further, some PATH respondents pointed out, it may not always benefit an organization or its clients to work with consumer practitioners who have "been there." One respondent said, "I have had folks who have been there, done that, and then said, 'I was able to do it by pulling myself up by my bootstraps and they can do the same; they don't need help.'" Interviewees suggested that this type of attitude usually becomes evident early in the working relationship and can be addressed before it becomes part of the organizational culture. This tendency can be discouraged through trainings and one-on-one discussions with staff, through collectively developing or revisiting the agency's mission statement, by restructuring and reframing the organizational culture, and by directly addressing this issue during the hiring process.

Challenges for Consumer Practitioners

Trading "clienthood" for professionalism can be problematic, Mowbray (1997) noted. Consumer practitioners often experience role confusion, discrimination from co-workers, feelings of being a "second class" employee, and feelings of being paid too little for their work (Chinman et al., 2000). Much of their stress may result from a "changing sense of self" in which the consumer practitioner is neither consumer nor professional but something else not clearly defined (Mowbray, Moxley, & Collins, 1998). Consumer practitioners may fear being co-opted into the professional workforce and losing their identity (Van Tosh, 1993).

Significant challenges to consumer practitioners cluster around some key themes, including stigma and workplace discrimination, client-staff boundaries, and job stress. Clearly, each of these also becomes a challenge to the agency charged with successfully supervising its consumer employees. These and other challenges are highlighted below.

Stigma and discrimination

Many of the challenges for consumer practitioners employed in PATH programs are related to and exacerbated by the stigma and discrimination that attaches to serious mental illnesses and to homelessness. Consumer practitioners may experience stigmatization and general distrust from staff who are not used to working with them as colleagues (Besio & Mahler, 1993). Attitudes toward consumer practitioners may be negative, fearful, exclusionary, guarded, and distant. One PATH consumer practitioner offered, "I just keep acting as normal as I can. But in some cases, I can see a real strain. It's a 'you vs. them' kind of thing. It's like, oh, I thought you were a professional, but I see, you're really a consumer."

Stigma and discrimination also can originate outside the agency when consumer practitioners interact with other providers and systems. The organizations interviewed try to overcome resistance with education. One consumer practitioner commented: "We let them know that we're a person first. We come to the table with different organizations. We're on [the State's] mental health planning council and a lot of committees. Instead of kicking and yelling and screaming, we take the high road, because we are the evidence that recovery is possible."

Tension between consumer practitioners and traditional staff

Discrimination can lead to, and be the result of, tension between consumer practitioners and traditional staff. This can be exacerbated when sharing and understanding the benefits of each other's work is not part of the organizational culture. One PATH respondent commented that "a great deal of the tension was [the result of] the traditional staff person's inability to understand, relate to, and deal with consumer/survivors either as co-workers, volunteers, or clients." A consumer practitioner explained, "We don't claim that we're foolproof; just like anybody else, we can make a misjudgment about a person and things may fall through. We just want the opportunity to try and the [acknowledgment] that what we're doing has worked with others."

This tension between the groups of staff may result in consumer practitioners feeling dominated or marginalized. For example, one consumer practitioner stated, "If we want to do peer programming, that's all well and good. But in actuality we're going to do as we're told and stay under the thumb or the power of the professional people." Another consumer practitioner noted that in a team meeting, the hospital doctor made clear that the psychotherapist who was working with a client would be "calling the shots." Consumer practitioners may feel they are being shut out of key decisions or given less responsibility than their non-consumer colleagues.

PATH respondents observed that the differences between traditional staff and consumer practitioners tend to diminish over time. Strategies for easing the tension include discussing issues in staff meetings and holding group social outings. Further, a strong and observant administrator can work to manage these types of problems, respondents believe.

Concerns about boundary issues

Frequently, consumer practitioners work with people they know and with whom they have a social bond. But the very trait that may be the key to a consumer practitioner's success—lack

of professional distance—can also cause significant problems when boundaries are unclear (Mowbray, 1997; Mowbray, Moxley, & Collins, 1998). Boundary issues are particularly challenging because consumer practitioners have a strong desire to help their clients and often develop deep connections with them, PATH respondents said. Frequently, friendships develop, but traditionally in mental health services, friendships are seen as unprofessional and perhaps unethical (Mowbray, Moxley, & Collins, 1998). Consumer practitioners may feel the strain of not knowing how to relate to people who are or could be their friends.

However, interviewees agreed that boundaries play a critical role, even in peer-driven models, because they aim to keep everyone safe and help clients develop their own personal networks. They also protect organizations against potential allegations of impropriety or abuse. One consumer practitioner noted, "Often people try to be friends, and I have to explain that there's a difference between being a peer mentor and being a friend. So we still have the traditional boundaries that have always existed in community mental health. We try to get people connected in the community and encourage them to make friends."

Many respondents spoke about trying to maintain a balance that allows consumer practitioners to be as humane, caring, and supportive as possible while having adequate policies in place so that staff and volunteers are not overworked or exposed to risk. Example policies mentioned by the responding organizations include not allowing staff to socialize with clients until 6 months after clients have left the program and prohibiting staff from lending money to clients. One interviewee explained:

> *There are certain rules, for example you don't take somebody home with you or you don't give somebody a ride in your car unless you have gotten to know them and you feel comfortable. You don't give out your home phone number and your address. But at the same time, everybody's on a first name basis. Nobody sits on the other side of a desk. So we really try to have only minimal boundaries—ones that are usually around safety or around folks having a chance to go home at the end of the day and not feel like they're taking the job with them.*

Boundaries are also an issue between consumer practitioners and traditional staff, particularly if the consumer practitioners are working in agencies that provided or continue to provide them with services. There is a lack of consensus on whether or not this is appropriate (Van Tosh, 1993). Further, many observers note that traditional staff may be tempted to act inappropriately as therapists for consumer staff (see further details below), and that normal reactions to a stressful job may be interpreted as psychiatric symptoms.

Confidentiality

The use of consumer practitioners raises confidentiality concerns; e.g., should they participate in team meetings in which their friends will be discussed? Also, what information should non-consumer staff have about consumer practitioners? When personal information is known, it can leave consumer practitioners feeling vulnerable and at risk of being judged, PATH respondents said. Everyone on the staff of a PATH-funded agency, including consumer practitioners, should

be trained in the confidentiality provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA).

Tensions around confidentiality issues can be minimized if programs make clear that their mental health providers are not to be asked for or to disclose personal or diagnostic information on consumer practitioners. “The only time we have information from their personal service providers is when they choose for us to know something they think may be helpful for them,” one PATH respondent said.

Questions about self-disclosure

Closely related to concerns about boundaries is the question of whether, and when, consumer practitioners should disclose their status as a recipient of services to their employer and to the clients with whom they work. As Dixon, Krauss, and Lehman (1994) point out, “what is ordinarily none of a prospective employer’s business becomes a job qualification.” Fisk et al. (2000) suggest that if the expected benefit of disclosure is to increase providers’ support for consumer employment, such disclosure may be most effective after the consumer practitioners have demonstrated their ability to do their jobs.

This dilemma relates to the larger question of whether positions are created specifically for consumers or whether affirmative hiring practices encourage all who are qualified to apply. In the end, Stephens and Belisle (1993) believe that most people need to know they hold a job based on skills and/or education and not primarily because of their user experience. To do otherwise, the authors contend, means the job will be experienced as paternalistic or tokenistic. They make recommendations for affirmative hiring practices that are highlighted in the final section of this report.

The issue of self-disclosure with clients is a particularly challenging quandary since some of the benefits of using consumer practitioners potentially might be lost if consumers choose not to self-disclose. PATH administrators, supervisors, and consumer practitioners vary in their opinions and approaches to self-disclosure. Several of the administrators and supervisors indicated that while they may not have written policies about self-disclosure, they train employees on what is and is not appropriate to share and generally discourage it unless it has clear potential for helping the client. Guidelines concerning disclosure are discussed during supervision and staff meetings, addressed in videos, and covered in trainings or through outside support groups or conferences.

One supervisor explained, “The practice is to limit disclosure. We do talk a lot with [our consumer practitioners] about being careful to not share too much or to share only what one feels comfortable sharing.” Another concurred by saying that “disclosure has to be for the benefit of our guests.” Still another respondent stated that staff are not free to self-disclose in groups. “We really believe that even for the non-consumer clinician to work on issues in a group with [their] clients is probably not appropriate.”

Consumer practitioners varied in their responses but generally thought that disclosure could be helpful to clients if done in a tailored and careful way. For example, one respondent felt it

important to "shape disclosure to keep it centered on the person." Another commented, "I would never use [self-disclosure] as a way to ingratiate myself with a potential client or a homeless person, or a kind of one-upmanship thing."

Several respondents did feel that disclosing to clients "is part of recovery," both theirs and the clients. One individual said, "Say I have something wrong in my life and I'm in recovery for that. Well, maybe there's somebody else who might be struggling with what has happened to them. And you can relate just little pieces [of your story], not [enough to upset them] but enough to help them with their recovery."

Job stress/ burnout

Consumer practitioners often assume roles as providers that are low status, low pay, and highly stressful—positions that are labeled as prone to burnout when mental health professionals fill them (Mowbray, 1997). Yet consumer practitioners may lack education and training to fill these roles, may be unclear about their responsibilities or how to meet them, and may feel overly responsible for their clients.

Indeed, several PATH consumer practitioners reported having trouble letting go of responsibilities at the end of the work day and felt they needed to learn to delegate better. Administrators agreed, with one noting that "they end up giving away time." This pressure comes from multiple directions. When asked if consumer practitioners feel that they have to be exceptionally competent, one respondent said, "Well, maybe a little better. But that's good because you really want to do a good job and you know you're not going to slough off."

Several interviewees agreed that consumer practitioners are often held to a different standard, in part because of the stigma that attaches to mental illness. One respondent said, "I always get a sense that people are looking more closely at peer mentors and how the job is going, even more so than with traditional staff. I think we're still proving ourselves, so we're more closely monitored." As a result, consumer practitioners may become especially dedicated to their jobs, but working under this additional pressure has consequences. "There's a lot more fear of making a mistake and having it reflect badly on the program," one consumer practitioner noted. Job stress may lead to an increase in symptoms for consumer practitioners (Besio & Mahler, 1993) and their absence from the job impacts the rest of the staff and the program's clients.

Fear of losing entitlement benefits

Having earned income is a significant benefit to employment for consumer practitioners, but they often are fearful of losing benefits and are, therefore, sometimes reluctant to return to the workforce. They may be restricted in the number of hours they work in order to maintain medical benefits, which means they can't earn enough to forgo assistance entirely. One PATH administrator explained, "We have several people who are on a fixed income and they have, with their advocates, determined how many hours they can work. We work around those hours each month."

Programs reported using a range of strategies to help people address benefits issues: one-on-one education and support (including accompanying individuals for meetings at the Social Security office), part-time jobs, peer support groups, money management classes, job coaches, connecting individuals to A Ticket to Work program, and using volunteer pools. The agencies that use volunteers feel that volunteering gives people a chance to test themselves and learn about potential job stresses and allows the agency a chance to get to know them, as well. Finally, many observers advocate that consumer practitioners receive the same compensation and benefits as their non-consumer colleagues who perform the same jobs (Van Tosh, 1993; Solomon & Draine, 1995).

Challenges for PATH Programs

As noted previously, each of the challenges consumer practitioners face also becomes a challenge for the agency that employs them. Addressing these challenges may require new policies and procedures, such as those around confidentiality, or they may simply require compassion and flexibility. Several challenges specific to PATH agencies are highlighted below.

Access to peer support networks

Programs that employ consumer practitioners need to have viable support systems in place to help workers sustain successful role performance and develop professionally (Mowbray, Moxley, & Collins, 1998). In particular, PATH respondents said, it is important that consumer practitioners quickly receive the peer support and direct support services they require when a need has been identified or they come forward and ask for help. No one can or should be forced to accept help, they noted, but in a supportive environment, consumer practitioners should have a variety of types of assistance available to them, such as a peer recovery network and peer specialist trainings.

One program noted that consumer practitioners look out for each other and may encourage those who are having problems to speak to their supervisors. "While we can't treat them differently and we can't force them to do things, quite often their coworkers' suggestions will prompt them to come in and talk to us and then, of course, we can guide them," one PATH supervisor said. "We can refer them to their doctor or a clinic appointment to see if we can get them some help or make adjustments to their schedule, if needed." Adjusting a person's work schedule to accommodate a disability is considered a reasonable accommodation under the Americans with Disabilities Act (ADA) (see below).

Fisk et al. (2000) make clear that while supervisors can refer individuals for additional supports, they must allow them to follow through. "Supervisors are responsible for the adjustment and work performance of staff, not their use of support networks," Fisk says. In particular, supervision is not intended to be therapy; supervisors should not offer or agree to provide clinical services to consumer practitioners, though in some cases this is exactly what happens (Francis, Colson, & Mizzi, 2002; Fisk et al, 2000; Dixon, Krauss, & Lehman, 1994). Clearly, supervisors want to provide as much support and encouragement as consumer practitioners need without crossing a line that creates role confusion for their staff.

To address these concerns, several of the respondent organizations offer formal Employee Assistance Programs (EAP) for all employees, flexible management and scheduling, one-on-one discussions and support, and the ability for consumer practitioners to attend group sessions and other support options during traditional work hours. One PATH administrator said, "It's my management style to be supportive and to try to help people have as smooth a time in the workplace as possible. I would probably do it in a very similar way if all of my employees were traditional employees. At the same time I hope I'm not taking care of people beyond what's healthy for them."

Complying with the Americans with Disabilities Act (ADA)

Agencies that employ consumer practitioners struggle with knowing the difference between job flexibility and reasonable accommodations; ideally, a mentally healthy workplace does both. As Fisk et al. (2000) point out, not every situation that involves adjusting the work responsibilities of consumer practitioners can be attributed to their disability. For example, sometimes flexible scheduling is something offered to all employees regardless of status; in other instances, a change in schedule may be related to an individual's illness or treatment.

The fluctuating nature of psychiatric disabilities requires creativity in applying the ADA. Individuals with mental illnesses may need various accommodations at different times or general flexibility rather than specific options. Also, individuals may be unaware of their rights under the ADA or unwilling to ask for accommodations for fear of reprisals (Francis, Colson, & Mizzi, 2002; Fisk et al., 2000). PATH respondents noted that consumer practitioners need to be educated about their rights under the ADA.

PATH consumer practitioners responded to a question about the need for reasonable accommodations by stating that they want to be treated as people first. "Being treated differently only slows down my recovery, because if I'm treated differently, I feel different," one consumer practitioner said. However, administrators and consumer practitioners agreed about the need for support and understanding. One respondent stated, "We don't look at people like they're mental illnesses. We look at them like they are people who every now and then just need a little bit of support." A consumer practitioner noted, "Everybody needs a little extra support one day and maybe not the next. Some days, I have a really, really good day. And then some days I just need that little extra boost to get me started."

Accommodations in the workplace are often related to flexibility with scheduling. Several PATH respondents noted that consumer practitioners often have unique needs that require scheduling adjustments and these adjustments can be challenging to an organization. One interviewee offered the example that "certain medications may preclude a consumer being assigned to a graveyard shift because when they take these medications, they have a hard time staying awake."

Administrators interviewed in all four of the PATH programs designated as exemplary reported working with people on the issue of scheduling. One administrator highlighted the importance of being able to work closely with consumer practitioners when they or their supervisors feel they have begun to decompensate and to shift their schedule to give them "the time off they need to

gather themselves together and move back toward productive employment. It takes a little bit of extra effort to do that and not adopt a hard-line attitude toward staff and scheduling," the administrator noted. Another reported "adjusting their schedule so they can go to school and get their education. Everyone is used to stepping in to help other employees get their job done knowing that in 6 months, they might be the one who needs assistance." Regardless of the specific circumstances, the consumer practitioner always should be consulted about the accommodations he or she feels are necessary.

Recommendations for Practice

Clearly, there are significant benefits and challenges to the use of consumer practitioners in PATH programs. Indeed, researchers have found that it is one thing for agency staff to support empowerment as an abstract goal but quite another to shift power to clients, away from themselves (Glasser, 1999). Yet as this report attests, PATH programs are successfully employing consumer practitioners to the benefit of clients, the consumer practitioners themselves, and the agencies they serve. Some specific recommendations for turning this vision into reality follow.

Develop a Clear Vision and Mission

To be successful in employing consumer practitioners, agencies must begin with a vision and a mission that supports the value of doing so. Support for hiring consumers should come from the agency's leadership. A visible mission and values that are shared by all makes it easier to resolve operational issues (Mowbray & Moxley, 1997b).

The PATH organizations chosen as exemplary for purposes of this report were ones in which the value of hiring and working with consumer practitioners came from the top down and the bottom up and permeated through the culture of the workplace. While they still had struggles, they were committed to making this work and acted daily to convey that message to clients and staff. Here is what some PATH respondents said in this regard:

- "We've been doing this for quite a while, so everyone knows that when you're working here, you'll be working alongside consumers, as well as working for consumers in providing assistance to them."

- "We are better at what we do and more understanding and accepting of people's challenges. We would not be anywhere nearly as successful a program if we didn't have consumer practitioners [or] if we didn't have peers as volunteers. It really is the whole key to this operation being successful."

- "They [consumers] have a priority for being hired; those are the people we look for. And several of our people have been homeless and have lived in a shelter, so they really have some background."

An agency with a clearly defined mission will also have specific policies that are communicated to all staff, particularly around confidentiality. Having clear, written protocols for dealing with confidential information is useful for all staff (Besio & Mahler, 1993). Consumer practitioners should be involved in developing and reviewing confidentiality procedures (Van Tosh, 1993).

Train and Educate All Staff

All staff in PATH-funded agencies need to be trained in basic skills to do their job well and educated about the important roles consumers practitioners play. They also need to be prepared to practice in a culturally appropriate manner.

Communicate job responsibilities clearly

For consumer practitioners, training can help them communicate more effectively and diffuse potentially difficult situations. Said one PATH respondent, "We had training before we became employees and I think this helped me out a tremendous amount. It helped my supervisor know me a little better [and assure us both] that I might be able to actually perform the duties that normally one doesn't get a chance to do."

Respondents reported offering or participating in a variety of training opportunities. Trainings were usually designed for and attended by all staff and covered topics such as ethics and confidentiality as well as job-specific duties. Not all PATH consumer practitioners felt that they received enough of this support, however. One commented, "There's little in-service training, so we really fly by the seat of our pants."

Training need not be formal. One supervisor noted the value of informal conversations around potential trouble spots. "We talk about why somebody, whether it's a consumer practitioner or a client, loses their cool so easily. What is it that trips them? We talk about trauma."

For individual consumer practitioners, formal job descriptions may lend identity and purpose to their work (Francis, Colson, & Mizzi, 2002). A sample job description for a peer specialist can be found at the Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases Web site, http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/ (click on Georgia Certified Peer Specialist Program).

Educate all staff about the role of consumer practitioners

Traditional staff may express misgivings about working with consumer practitioners, but education can overcome their reluctance (Glasser, 1999). Topics for these sessions might include (Fisk et al., 2000):

- History of the consumer practitioner movement
- Contributions that people with mental disorders have made to PATH-funded projects
- Success of current consumer integration efforts
- Potential for recovery from mental disorders
- First-person accounts from consumer practitioners

The most effective training will have consumers involved as part of the training staff. Joint leadership of consumer and non-consumer staff in these education and training efforts demonstrates an important partnership between the two groups (Fisk et al., 2000; Van Tosh, 1993).

Practice cultural competence

Agencies that expect to treat all clients and staff with equal respect must adhere to principles of cultural competence. According to the U.S. Surgeon General's report *Mental Health: Culture, Race, and Ethnicity* (HHS, 2001), "culture is important because it bears upon what *all* people

bring to the clinical setting." As defined by the PATH Cultural Competence Workgroup, cultural competence is "an ongoing and evolving process that comprises knowledge attainment and the development of behaviors, attitudes, policies, and practices that come together in a system of care enabling agencies, programs, and individuals to increase access to services and to develop or adapt services that are appropriate to specific cultural needs" (PATH, 2002). Cultural competence requires ongoing education, training, and organizational and managerial commitment at all levels of the organization, as well as appropriate public policy and consumer involvement.

Offer Individual Supervision and Support

Individual supervision is an important support for consumer practitioners who are adjusting to work positions in mental health settings (Fisk et al., 2000). In particular, Fisk notes, clinical programs that employ consumers must be alert to both overt and covert discrimination and provide opportunities for consumer practitioners to talk openly in individual supervision sessions or staff meetings about situations that may involve discrimination.

However, as noted in the previous section, supervisors must be careful to distinguish between supervision and therapy. Here is how one PATH supervisor handles individual supervision:

> *I just make myself very available. I'll call in on everybody's shift, so nobody feels like they're being singled out, and I try to be as supportive as I can. We have private supervision and we have regular staff meetings, and I tell [staff] they can call at any time for any reason. At staff meetings, everybody brings up concerns and every concern goes on the agenda.*

In addition to supervision, peer support groups initiated by and for consumer practitioners could be helpful in providing mutual aid (Van Tosh, 1993; Fisk et al., 2000). These could be at or near the job site, though Dixon, Krauss, and Lehman (1994) believe there is "no substitute for on-site job support."

Value Consumer Positions

There are a number of ways in which agencies that employ consumer practitioners can show their support for the roles that consumers play. For example:

- Recognize direct experience as a recipient of mental health services and/or homelessness as unique and legitimate skills in developing job posting and other recruitment strategies (Van Tosh, 1993).

- Encourage parity for compensation and other benefits between consumer practitioners and other workers performing the same duties and/or in the same position (Van Tosh, 1993). Said one PATH respondent, "I think money really talks in a job; that's the way our culture shows which jobs are most important."

In their study of a randomized trial of consumer case management, Solomon and Draine (1995) note that consumer case managers received pay and benefits comparable to the non-consumer case managers in the same mental health system. "To assume that hiring consumers would lessen the cost of providing case management services continues to relegate consumer-delivered services to a second-hand status," the investigators report. Though some may justify lesser pay on the basis of lesser qualifications in terms of formal education, Solomon and Draine believe "this only further denigrates the validity of life experiences as acceptable preparation for case management work."

- Educate others about the fact that consumer practitioners must have affordable housing in order to work or perform other meaningful activities (Van Tosh, 1993).

Treat Staff Equally

Equal pay for equal work is only part of the equation. PATH respondents and experts who have studied the role of consumer practitioners in mental health settings encourage agencies to minimize the differences between consumer and non-consumer staff. Consumer practitioners should be treated like any other employee with similar roles or responsibilities; neither substandard expectations nor separation is appropriate (Mowbray and Moxley, 1997b). When consumer practitioners are "seen for their capabilities and their abilities, and not just as their disability or their diagnosis, it seems to help them to move forward and get into the workforce and become more independent," one PATH respondent said.

Indeed, Stephens and Belisle (1993) believe that "the definitional limits that frame our constructs of who is a consumer and who is a provider promote the same inhumane 'hardening of the categories' that necessitated consumer-initiated reform of mental health services in the first place." They believe that diversity in the mental health work force and systems that are inclusive and consumer-driven should consider the following principles:

- A broad-based affirmative action plan can be of greater value to all consumers and providers than a focused consumer-as-provider initiative.
- The degree of experience of exploitation, victimization, and disenfranchisement is not germane to the definition of who is a consumer.
- Sensitivity to the needs of the consumer, whether acquired as a function of being a consumer or not, is the essential element in developing competent, humane systems.
- The professional tradition of separating personal and professional experiences should be reexamined: discreet clinical situations may argue against disclosure of personal experience whereas system-building may require it.
- Opportunities for job training, job enhancement, and job enlargement are the prerequisites for successful staff development of consumer and non-consumer providers alike.
- The boundaries between the labels consumer and provider are not necessarily as rigid as is assumed by conventional language.

Communicate the Message That Recovery Is Possible

Recovery for people with serious mental illnesses is the ultimate goal of a transformed mental health system. The use of consumer practitioners in PATH-funded agencies that serve people with serious mental illnesses who experience homelessness communicates to clients and to the consumer practitioners themselves that recovery is possible, that it is a valued goal, and that employment is an important component to mental health recovery.

Further, successful integration of consumer practitioners into PATH programs sends an important message to traditional staff and to outside agencies and systems that individuals with serious mental illnesses who experience homelessness can and do recover and they can play an important role in the delivery of mental health services to their peers. Said one PATH respondent, "A lot of the people we've worked with have become recovery educators and now have jobs working in different mental health agencies. They went from feeling that they had no ability to have a job to actually finding work." Thus, it's clear that PATH-funded agencies that employ consumer practitioners play an important role in mental health transformation.

Recommendations for Policy

The previous set of recommendations is a roadmap of successful practices for administrators and staff in PATH-funded programs to hire, train, and support consumer practitioners. At the policy level, State PATH Contacts have an important role to play, as well. They must advocate increasing the employment of consumers with significant experiences of homelessness in the agencies they fund with PATH monies. In particular, State PATH Contacts can:

- Identify expectations for local providers that include hiring consumers who have experienced homelessness to provide outreach, case management, and peer support services
- Provide technical assistance and training to help PATH-funded agencies hire and train mental health consumers who have experienced homelessness and network with one another and with their colleagues in other States who employ consumers
- Survey local providers to determine the extent to which they use consumer practitioners, any barriers they encounter, and successful strategies they employ
- Use this information to help shape technical assistance and to guide future funding decisions

Ultimately, State PATH Contacts can be an important catalyst for mental health transformation within the PATH program and the broader mental health system by expecting the providers they fund to hire consumers who have experienced homelessness; by providing the technical assistance to help both the agencies and the individuals they hire to be successful; by and encouraging and supporting networking and educational opportunities.

References

Besio, S.W., and & Mahler, J. (1993). Benefits and challenges of using consumer staff in supported housing services. *Hospital and Community Psychiatry, 44*(5), 490-491.

Campbell, J. (2005, December). Effectiveness findings of the COSP Multisite Research Initiative. *Grading the evidence for consumer-driven services*, UIC NRTC Webcast, Chicago, IL.

Chinman, M.J., Lam, J.A., Davidson, L., & Rosenheck, R. (2000). Comparing consumer and non-consumer provided case management services for homeless persons with serious mental illness. *Journal of Nervous and Mental Disease, 188*(7), 446-453.

Dixon, L., Krauss, N., & Lehman, A. (1994). Consumers as service providers: The promise and challenge. *Community Mental Health Journal, 30*(6), 615-634.

Federal Task Force on Homelessness and Severe Mental Illness. (1992). *Outcasts on main street: Report of the Federal task force on homelessness and severe mental illness.* Washington, DC: Interagency Council on the Homeless.

Felton, C.J., Stastny, P., Shern, D.L, Blanch, A., Donahue, S.A., Knight, E., et al. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. *Psychiatric Services, 46*, 1037-1044.

Fisk, D., Rowe, M., Brooks, R., & Gildersleeve, D. (2000). Integrating consumer staff members into a homeless outreach project: Critical issues and strategies. *Psychiatric Rehabilitation Journal, 23*(3), 244-252.

Francis, L.E., Colson, P.W., & Mizzi, P. (2002). Beneficence vs. obligation: Challenges of the Americans with Disabilities Act for consumer employment in mental health services. *Community Mental Health Journal, 38*(2), 95-110.

Glasser, N. (1999). Giving voice to homeless people in policy, practice, and research. In L.B. Fosburg & D.L. Dennis (Eds.), *Practical lessons: The 1998 national symposium on homelessness research.* Washington, DC: U.S. Department of Housing and Urban Development & U.S. Department of Health and Human Services. http://aspe.hhs.gov/homeless/symposium/5-CONSUMR.htm

Lyons, J.S., Cook, J.S., Ruth, A.R., Karver, M., & Slagg, N.B. (1996). Service delivery using consumer staff in a mobile crisis assessment program. *Community Mental Health Journal, 32*(1), 33-40.

Mowbray, C.T. (1997). Benefits and issues created by consumer role innovation in psychiatric rehabilitation. In C.T. Mowbray, D.P. Moxley, C.A. Jasper, & L.L. Howell (Eds.), *Consumers as providers in psychiatric rehabilitation.* Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Mowbray, C.T., and Moxley, D.P. (1997a). A framework for organizing consumer roles as providers of psychiatric rehabilitation. In C.T. Mowbray, D.P. Moxley, C.A. Jasper, & L.L. Howell (Eds.), *Consumers as providers in psychiatric rehabilitation*. Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Mowbray, C.T., & Moxley, D.P. (1997b). Consumers as providers: Themes and success factors. In C.T. Mowbray, D.P. Moxley, C.A. Jasper, & L.L. Howell (Eds.), *Consumers as providers in psychiatric rehabilitation*. Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Mowbray, C.T., Moxley, D.P., & Collins, M.E. (1998). Consumers as mental health providers: First-person accounts of benefits and limitations. *The Journal of Behavioral Health Services and Research, 25*(4), 397-411.

National Association of State Mental Health Program Directors. (1989). *Position statement on consumer contributions to mental health service delivery systems*. Alexandria, VA: Author. www.nasmhpd.org/general_files/position_statement/contribps.htm

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America.* Final report. DHHS Pub. No. SMA-03-3832. Rockville, MD.

Solomon, P., & Draine, J. (1995). One-year outcomes of a randomized trial of consumer case management. *Evaluation and Program Planning, 18*(2), 117-127.

Solomon, P. & Draine, J. (1994). Satisfaction with mental health treatment in a randomized trial of consumer case management. *Journal of Nervous and Mental Disease, 182*(3), 179-184.

Stephens, C.L., & Belisle, K.C. (1993). The "consumer-as-provider" initiative. *Journal of Mental Health Administration, 20*(2), 178-182.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: Center for Mental Health Services.

Van Tosh, L. (1993). *Working for a change: Employment of consumers/survivors in the design and provision of services for person who are homeless and mentally disabled.* Rockville, MD: Center for Mental Health Services.

Van Tosh, L., & del Vecchio, P. (2000). *Consumer-operated self-help programs: A technical report*. Rockville, MD: Center for Mental Health Services.

Watson, A.C., & Corrigan, P.W. (n.d.). *The impact of stigma on services access and participation*. The Behavioral Health Recovery Management Project. Accessed June 26, 2006, from www.bhrm.org/guidelines/stigma.pdf.

Appendix A
PATH Consumer Involvement Questionnaire

_____

State

1. How many programs receive PATH funds in your state? _____.

2. Please identify the total number of PATH providers in your State that use **paid/employed** (paid no less than an hourly minimum wage) mental health consumers to deliver PATH service(s). _____.

3. Of the **paid/employed** MH consumers delivering PATH service identified in Question # 2, how many have experienced homelessness? _____.

4. Please identify the total number of PATH providers in your State that use **volunteer** (paid less than hourly minimum wage) mental health consumers to deliver PATH service(s). _____.

5. Of the **volunteer** MH consumers delivering PATH service identified in Question #4, how many have experienced homelessness? _____.

6. For those identified in Question #2, using the *box*, please identify the total number of **paid/employed** (no less than an hourly minimum wage) mental health consumers and related FTE's.

Total # Employed Consumers	Total # Related FTE's

7. Please check those Service Specifications, which use:

<u>Employed (no less than an hourly minimum wage) MH Consumers to Deliver:</u>

- ❑ Outreach Services
- ❑ Screening and Diagnostic Treatment Services
- ❑ Habilitation and Rehabilitation Services
- ❑ Community Mental Health Services
- ❑ Alcohol or Drug Treatment Services
- ❑ Staff Training
- ❑ Case Management Services
- ❑ Supportive and Supervisory Services in Residential Settings
- ❑ Referrals for Primary Health Services, Job Training, Educational Services, and Relevant Housing Services
- ❑ Other (please describe)_____
  _____

Volunteer (less than an hourly minimum wage) MH Consumers Deliver:

- ❑ Outreach Services
- ❑ Screening and Diagnostic Treatment Services
- ❑ Habilitation and Rehabilitation Services
- ❑ Community Mental Health Services
- ❑ Alcohol or Drug Treatment Services
- ❑ Staff Training
- ❑ Case Management Services
- ❑ Supportive and Supervisory Services in Residential Settings
- ❑ Referrals for Primary Health Services, Job Training, Educational Services, and Relevant Housing Services
- ❑ Other (please describe)_____
  _____

8. How many of the PATH providers in your state utilize consumer satisfaction surveys for feedback about their services? _____.

9. What other ways are utilized by providers to gain consumer input that is specific to their PATH programs:
   - ❑
   - ❑
   - ❑

10. Are there additional ways in which you feel consumers could be involved or more involved with the PATH programs in your state? If so, how
    - ❑
    - ❑
    - ❑

Appendix B
Exemplary Program Criteria

1. ***All Consumer Staff must meet a hiring criteria*** including:
    - An individual determined by a licensed professional as having a serious and persistent mental illness (SPMI);
    - Having experienced significant interruption of daily life in the community;
    - Having experienced homelessness;
    - Representing the population served;
    - The ability and willingness to convey their personal story of recovery to others as a living model.

2. ***More than one consumer staff is employed in the Exemplary Program*** in recognition of the importance and benefit of peer support.

3. ***All Consumer Staff are fully integrated into the work environment*** with no recognizable difference between consumer staff and non-consumer staff, including:
    a. Work assignments, expectations, contributions;
    b. Environment, office space;
    c. Salary, benefits;
    d. Career Opportunities and advancement potential.

4. ***All Consumer Staff receive ongoing supports provided by the agency*** to succeed at the job including:
    a. Agency paid training, credentialing, certification;
    b. Peer Supervision, peer support.

5. ***Each consumer staff receives job preparation assistance from the hiring agency*** prior to beginning employment that is equal to every other new hire which includes:
    a. New hire orientation training;
    b. A clear/written job description specific to performance expectations.

6. ***The hiring agency reviews barriers that might impact consumer employment*** with each Consumer Staff including:
    a. Transportation issues;
    b. Impact on SSI/Benefits;
    c. Relapse Issues.

7. ***The entire agency/organization demonstrates and portrays commitment to consumer employment*** as reflected in:
    a. Support of Recovery Philosophy;
    b. Leadership, top-down training;
    c. Mission State/Mission/Policies/Procedures.

Appendix C

Draft Interview Questions—Administrator/Supervisor Version

1. When and how was the decision made to hire consumers as staff in this PATH program?
2. Why was this decision made?
3. What is the number, total FTE of consumer staff members in your PATH program?
4. What is their role in the PATH program?
5. Are Consumer Staff paid the same as non-consumer staff?
6. What advantages have you noticed having consumer staff members?
7. What challenges have you identified? How have they been addressed?
8. How often and by whom is supervision provided to consumer staff?
    a. Have there been particular approaches to supervision that have been successful? What are they?
    b. Have there been particular challenges with supervision?
    c. If so, how have they been addressed?
9. Were consumers prepared for the transition to a staff role?
    a. If yes, what strategies have helped with this transition?
    b. What specific challenges have you faced helping consumers with this transition and how have they been addressed?
10. Do consumer staff also receive services from your agency?
    a. If yes, have there positive consequences from this?
    b. Have there been challenges as a result of this?
    c. How have challenges been addressed?
11. Are their additional supports in place for consumer staff? What are they?
    a. What specific strategies for supporting consumer staff have you found to be successful?
    b. What challenges have you faced in attempting to provide supports for consumer staff?
    c. How have these challenges been addressed?
12. Do Consumer Staff receive ongoing training? Is this different than what professional staff receive?
13. How do consumer staff relate to professional staff?
    a. In what ways have consumer and professional staff worked well together
    b. Have you identified strategies that help facilitate that positive relationship?
    c. Have there been issues, tensions?
    d. How have they been addressed?
14. Were professional staff prepared in any way for the implementation of the consumer staff role?
    a. What worked to prepare professional staff to work well with consumer staff?
    b. What challenges did you face preparing professional staff to work with consumer staff?
    c. How were they addressed?
15. How are the roles of consumer staff and professional staff defined in relation to each other? How do these staff understand the difference and how they are to relate to each other?

16. Have you altered administrative policies and procedures to reflect the consumer staff role? How?
17. Have you encountered difficulty recruiting qualified candidates for consumer staff positions? If so, please describe. Follow-up: to what extent has transportation or fear of loosing disability benefits prohibited otherwise qualified candidates from accepting paid employment?
    a. What has worked to recruit qualified candidates?
18. Are there times when being in a consumer staff role is itself stigmatizing?
19. How have boundary issues been addressed between consumer staff and current consumers, between consumer staff and friends who are still consumers, between consumer staff and current staff from whom they have or still receive services?
    a. What specific strategies have worked in this regard?
    b. What challenges do you still face?

Appendix D

Draft Interview Questions—Consumer Practitioner Version

1. What is your role in the PATH program?
2. What advantages have you noticed being a consumer staff member?
3. What challenges have you identified/faced? What have you done to address them?
4. How often and by whom do you receive supervision?
    a. Have there been particular approaches to supervision that have been helpful? What are they?
    b. Have there been particular challenges with supervision?
    c. If so, how have they been addressed?
5. Were you prepared for the transition to a staff role?
    a. If yes, what strategies helped with this transition?
    b. What specific challenges have you faced making this transition and how have they been addressed?
6. Do you receive services the same agency that you work for?
    a. If yes, have there positive consequences from this?
    b. Have there been challenges as a result of this?
    c. How have challenges been addressed?
7. Are their additional supports in place for consumer staff? What are they?
    a. What kinds of support have been most helpful
    b. What kinds of support have not been helpful?
8. Do you receive ongoing training? Is it the same/different from what professional staff receive?
    a. What kinds of training have been most helpful?
    b. What kinds have been least helpful?
9. How do consumer staff relate to professional staff?
    a. In what ways have consumer and professional staff worked well together?
    b. Have you identified strategies that help facilitate that positive relationship?
    c. Have there been issues, tensions?
    d. How have they been addressed?
10. How are the roles of consumer staff and professional staff defined in relation to each other? How do these staff understand the difference and how they are related to each other?
11. Are there times when being in a consumer staff role is itself stigmatizing?
12. To what extent was transportation, or fear of loosing disability benefits a barrier to you accepting this position?
    a. Are there other issues that make it challenging to keep this job?
    b. What has helped you to meet these challenges?
13. How have boundary issues been addressed between consumer staff and current consumers, between consumer staff and friends who are still consumers, between consumer staff and current staff from whom they have or still receive services?
    a. What specific strategies have worked in this regard?
    b. What challenges do you still face?

Appendix E
Exemplary Program Descriptions

Since 1988, the ***Brattleboro Area Drop In Center*** in Vermont has operated a day shelter for those experiencing homelessness—providing case management, street outreach services, advocacy, and a Community Food Shelf that serves Brattleboro and 47 surrounding towns. The Center also works to help prepare people who experience homelessness for part or full-time work. This includes case management and support services and training intended to help the clients find and keep a job.

The Center started small with only one half-time staff person, but currently has five full- and part-time staff members and approximately 35 volunteers. Originally, there were no consumer/ survivors on staff, but the Center now recruits more broadly in an effort to achieve 50 percent consumer representation on its board. Some board members are later hired to be employees. At the time of this project, the Center employed two consumer practitioners funded by PATH and an additional consumer practitioner funded by Department of Labor monies for people over age 55. In addition, the Center worked with one night outreach volunteer who has been with the agency for 12 years and whose expenses (e.g., mileage) are paid for by PATH.

Contact Information*:* Melinda Bussino, Brattleboro Area Drop In Center, PO Box 175, Brattleboro, Vermont 05302, (802) 257-5415/(800) 852-4286, badic@together.net

The ***West Virginia Mental Health Consumer Association (WVMHCA)*** is a non-profit service agency, funded primarily by the West Virginia Office of Behavioral Health Services. Started in 1987, the Association strives to promote "the rights, representation, respect, and responsibility for consumers of mental health services." WVMHCA conducts outreach to individuals experiencing homelessness; serves as a liaison to consumers being released from the State hospital; provides some transitional housing (90 days); and operates several drop-in centers.

WVMHCA also started small with two employees but has grown to a staff of 22, with an additional 55 volunteers serving consumers in 18 offices throughout the State. The Association leads several projects including: 1) the PASS program, which has been staffed solely by consumer practitioners since its inception; 2) the West Virginia Leadership Academy, a grassroots, consumer-operated, evidence-based program that teaches self-help skills, collective advocacy, leadership skills, community involvement strategies, issue awareness, and action plan development; 3) Wellness Recovery Action Planning (WRAP); 4) a 6-week Recovery Education course, together with West Virginia State College, that is staffed by peers who have gone out into the workforce; and 5) a Peer Recovery Network that links with treatment centers.

Contact Information: Kim Murphy, West Virginia Mental Health Consumers Association P.O. Box 11000, Charleston, West Virginia 25339, (304) 345-7312/(800) 598-8847, www.contac.org

The Salvation Army of Las Vegas, Nevada, has been serving the Las Vegas/Clark County area since 1945 and has operated its PATH program since 1993. With a catchment area that includes the communities of Las Vegas, Henderson, North Las Vegas, Boulder City, Lockland, and

Mesquite, and a population of about 1.6 million, the program provides a range of services. These include a day resource center; an adult rehabilitation program for both short- and long-term addiction treatment; an emergency kitchen that provides about 250,000 meals a year at the shelter and on the streets; a 156-bed emergency shelter for men, women, and children; a Safe Haven shelter that provides temporary housing for people with serious mental illnesses who experience homelessness; a 42-bed group home; and vocational training and placement. The Salvation Army operates a 5-acre campus downtown and accepts individuals daily with emergency situations.

Recognized as a PATH Exemplary Program Initiative Award Recipient (1999), The Salvation Army has employed consumers as lodging managers, secretaries, drivers, support staff, peer counselors, janitors, staff monitors, light duty security personnel, and mental health technicians.

***Contact Information**:* Rev. B. Duane Sonnenberg, Salvation Army, Clark County Command, Homeless Services, Las Vegas, Nevada, (702) 657-0123, ext. 15, duane_sonnenberg@usw.salvationarmy.org

The ***Vermont Psychiatric Survivors (VPS)*** program is a "consumer/survivor organization trying to fight tokenism, stigma, ignorance, and disunity among advocates." VPS works in partnership with the Claire Martin Center and NAMI to oversee the Safe Haven program, located in Randolph, VT. Safe Haven is an innovative 6-bed shelter that is licensed as a Therapeutic Community Residence. It is one of only a few programs in the country where a partnership exists between a consumer group and a mental health agency with each partner having equal power. This partnership was formed to implement a unique initiative for providing services to consumers, by consumers.

VPS began as a sponsor of peer-run support groups that could be for support, educational, or social purposes. Today, there are 12 peer support groups around Vermont receiving anywhere between $300 and $1,200 a quarter to run their activities. Fully consumer-run, VPS also has six paid staff.

***Contact Information**:* Linda Corey, Vermont Psychiatric Services, 4 Highland Avenue, Randolph, Vermont 05060, (802) 775-6834/(800) 564-2106, vpsinc@sover.net, www.sover.net/~vpsinc/

Appendix F
PATH Consumer Involvement Workgroup Participants

Members

Mary Murphy	Maine	mmurphy@preblestreet.org
Linda Corey	Vermont	vpsinc@sover.net
Brian Smith-**PATH**	Vermont	bmsmith@vdh.state.vt.us
Melinda Bussino	Vermont	badic@together.net
Jay Entwisle	Vermont	badicjay@together.net
Sherry Jenkins-Tucker	West Virginia	sherryjenkinstucker@contac.org
Jackie Chellew-**PATH**	West Virginia	jackiechellew@wvdhhr.org
Kim Murphy	West Virginia	KimMurphy@contac.org
Elizabeth Ledbetter-**PATH**	Tennessee	Liz.Ledbetter@state.tn.us
Lea Haynie	Tennessee	lea.haynie@state.tn.us
James Waldon	Tennessee	jwaldon@vbhcs.org
Richard Thomas	Tennessee	rbtmanna@yahoo.com
Marcia Armstrong-**PATH**	Montana	marmstrong@state.mt.us
Dan Powers	Nebraska	Dan.Powers@hhss.state.ne.gov
Jimmy B.	Nebraska	JimmyB1375@yahoo.com
Bill Turner	Oregon	wturner@nwhumanservices.org
Dave Allen	Michigan	dallen@swcds.org
Charley Bliss-**PATH**	Georgia	cbliss@dhr.state.ga.us

Presenters

Dave Dixon	Georgia	dave@homelessauthority.org
Beth Filson	Georgia	emfilson@dhr.state.ga.us
Ellen Starrett-Leslie	Georgia	Ellen.Starrett@DOL.State.GA.US