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TECHNICAL REPORT

Mental Health Consumer Providers

A Guide for Clinical Staff

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RAND HEALTH

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Mental Health Consumer Providers: A Guide for Clinical Staff

"Michelle and Kim," painting by Magdalena Astrid Dahlen. Printed with permission of the artist.

Preface

The purpose of this booklet is to provide mental health clinic staff with a brief guide to implementing and sustaining a consumer provider program.

Consumer providers (CPs) are individuals with serious mental illness who are trained to use their experiences to provide recovery-oriented services and support to others with mental illness in a mental health service delivery setting.

The information in this booklet comes from multiple sources. One of these sources is research that was conducted on location at Lamp (Los Angeles Men's Project, which originally served only men) Community, a nonprofit organization in downtown Los Angeles that serves people who are homeless or formerly homeless and have a mental illness. Lamp Community has been a national leader in providing services—including CP services—to this population for many years. Research at Lamp Community included interviews with administrators, staff, CPs, and residents. Interviews were conducted to understand the history of CPs in the organization, the future of CP programs, and the ideal organizational structure for CP services. Lamp Community's participation helped ensure that this booklet's contents are relevant for provider organizations that serve individuals with mental illness.

Information from the Lamp Community interviews was enhanced by interviews with national experts on the topic of CP services. Throughout this booklet, individuals who participated in the research will be referred to as *participants*. Another source of information for this booklet was literature in the form of journal articles, books, and reports on CP programs.

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Mental Illness Research, Education and Clinical Center. UCLA/RAND NIMH Center projects typically have a strong focus on community-based research and involve collaboration with community agencies, health care practices and plans, purchasers, and consumer groups, both locally and nationally. Through this collaborative approach, the center's broad goal is to effectively use research to improve public mental health and mental health care delivery in ways that are consistent with the goals, priorities, and resources of diverse stakeholders.

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Acknowledgments

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Topics Covered

Several topics are covered in this booklet, including the benefits of having CPs on staff, suggestions to facilitate the hiring of CPs, typical barriers to hiring CPs, components of a formal CP program that should be considered, and issues for the future of CP programs.

This booklet is designed to be an easy-to-use reference guide. For example, it could be used by

- staff and consumers within agencies that are working to strengthen or expand consumer involvement
- agency leaders or employers who are considering whether to hire consumers as providers
- consumers who are interested in applying for provider positions
- family members, consumers, or others who are interested in advocating for the creation of CP positions.

This booklet is not an exhaustive presentation of guidelines, issues, and benefits in using mental health consumers as providers and should be supplemented by more detailed materials and extensive consultation with experts in the field of recovery-oriented mental health. Suggestions for further reading are provided at the end of this booklet.

Benefits of Hiring Consumers

The idea of "recovery"—in which providers and individuals with mental illness work collaboratively toward the individual's pursuit of a meaningful and enriched life in the community—is the focus of mental health treatment today. One important strategy for making mental health care more recovery-oriented is to have mental health consumers serve

as providers in mental health clinics and other mental health organizations. CPs offer many advantages:

- serve as role models to consumers
- voice and broker the needs of consumers
- are an important sources of information
- serve as a powerful source of motivation
- help others while helping themselves
- serve as mentors to others, helping them to better understand paths to recovery.

For the systems in which they work, CPs

- assist clients in navigating often-fragmented service systems
- are often more willing than nonconsumer staff to perform needed client support activities, such as transportation and life skills development
- serve as a unofficial liaisons with nonconsumer staff, interpreting and in some cases mediating between staff and clients
- challenge unacknowledged stigma and bias toward clients
- augment the services of overburdened mental health systems, thereby increasing access to services.

"What I like about the CPs is that they have the ability to listen to something and hear it totally differently than regular staff because they have been there. . . . They understand what a person is going through, and they have a lot of good insight into some solutions." (Administrator)

Given the benefits listed above, it is hard to imagine that any mental health clinic would not want to have CPs as part of its staff. However, employing CPs in this way is new, meaning that most of today's mental health workforce may be only minimally familiar with CPs and may have no experience in setting up CP programs. As with all new efforts, resistance is possible. Thus, it will be important to think through the adjustments and actions that should be taken to effectively incorporate consumers as providers.

Consumer Provider Employees

Before laying out the various components of a CP program, it is important to note that there is more than one way to create an effective and sustainable program. A program in its first year may look quite different from a program two years later, but both may be equally effective. Our goal is to provide some general guidelines for implementing a CP program, though we wish to emphasize that staff development programs should be flexible, responsive to the organization and its customers, and sensitive to the needs of all employees. Also, the success of a CP program depends on the full buy-in and support of leadership and staff and on the existing organizational culture.

Recruitment

Recruitment of CPs can be challenging. It is legal to consider experience with the receipt of mental health services as a job qualification for CPs. Nonetheless, it may be awkward to ask about a psychiatric disability during the hiring process. Including language related to such experiences in the posted job description is one option, as is reference to this in the job interview. For example, one might say, "As one who has availed themselves of mental health services, the CP will share their own experiences and what skills, strengths, supports, and resources they use. As much as possible, the CPs will share their own recovery stories and will demonstrate how they have directed their own recovery processes."

"The [CPs] are good for motivating and helping other people find strengths that they don't know that they have. . . . They are very good at being there with the person and working with the person, and that is why I feel that I need more of them." (Administrator)

This language conveys that experience with mental illness is among the many attributes that are positively valued. Then, employers can ask whether candidates meet this criterion.

Recruitment for CP positions may be handled in a variety of ways. One possibility is to post a job opening within the local community. Another possibility is to post the opening both within and outside the local community. Yet another possibility is for staff to identify individuals who might be

effective CPs and then to talk with those individuals about job opportunities.

Hiring

When hiring CPs (as when hiring any other staff), multiple stakeholders should have the opportunity to give input, with multiple interviews and screening procedures. Thought should be given to ensuring that eligibility criteria are appropriate for the position. For example, what education level does the position require? Should there be a specific length of time in which the candidate has been free of hospitalizations or substance misuse? For example, some organizations require six or 12 months without a hospitalization or active substance misuse.

Job Description/Job Structure

"I do outreach so my familiarity with the day-to-day is a factor. I know where people are at. I receive the services myself so I know what it's like to be somebody receiving the services or trying to receive the services. I have an insight to what barriers they might have and insight on how to remove those barriers." (CP)

One of the most important factors in determining whether an employee hired as a CP will be successful is the clarity of his or her job description. Below is a list of important questions to consider when preparing CP job descriptions:

What are the organization's goals in hiring consumer providers?

Answering this question will reveal a great deal about an organization's readiness to employ a CP. Care should be taken not to hire CPs simply as a less expensive option to fill staff vacancies or to do tasks that other staff do not want to do (e.g., transporting or escorting clients). An appropriate goal for employing CPs is to provide those in treatment with access to individuals already in recovery. CPs not only share ideas about what works for recovery, but their presence in an organization signals that recovery is possible and that the organization values consumer input.

What are the specific job duties of the consumer provider?

This will vary depending on the needs of the particular organization and on the skills of the CP candidate. CPs can

perform a wide variety of job functions. Here are some of the duties that CPs have performed:

- helping clients attend their appointments
- addressing housing, financial, and recreational needs
- encouraging clients to become more integrated with their communities—for example, helping clients find activities that would facilitate the development of key skills and encouraging participation in those events (which could involve taking the client to the event)
- working with clients to articulate personal goals for recovery and helping them to achieve those goals
- facilitating client access to self-help groups
- conducting wellness planning
- teaching problem-solving skills
- providing vocational, residential, and social rehabilitation
- enhancing the system's recovery orientation by advocating for effective recovery-based services
- providing the "client's point of view" at team meetings, treatment planning meetings, and psychiatrist visits (although this should not be a substitute for working directly with and including consumers as often as possible)
- facilitating and/or leading peer support groups
- conducting consumer outreach in the local community
- serving as a resource to help clients explore activities that in the past gave them meaning and purpose. For example, if a client has been institutionalized for a significant period of time, the CP can help that individual

"[CPs] are the natural support experts. They should learn what is in their communities. They serve as great translators from clinical team member to user and vice versa." (Expert)

reconnect with meaningful activities, such as photography, art, writing, singing, etc.

These job duties are made possible when CPs develop trusting relationships with clients and make them feel safe and comfortable.

How will the confidentiality of the clients served by the team be maintained?

CPs, like all other employees, should be expected to conform to the standards of confidentiality at all times. CPs should receive training and supervision to reinforce those standards. CPs should be held accountable, like other employees, if they violate the standards.

Will the consumer providers have their own caseloads, or will they share caseloads?

This may vary, depending on the needs of the organization. For example, it might not make sense for CPs to have their own caseloads in organizations that are not able to be reimbursed for services performed by CPs. Also, some CPs have reported being able to forge a deeper relationship with clients because they were not burdened with the administrative responsibilities of being the "primary clinician." Conversely, other CPs have reported that, without their own caseloads, they feel marginalized on their team, like a "second-class" clinician. The final decision about the CP's role should take into account the needs of the organization, the clients, and the CPs themselves (i.e., some CPs may want to have caseloads, while others may not).

Will the consumer providers be responsible for recording notes on the clients' charts?

This depends on the role of the CP—namely, if he or she has any clinical responsibilities. If CPs do have clinical contact, it is appropriate for them to document their contact. It may be necessary for them to do so in order for the

organization to be reimbursed for those services. Also, it is good clinical practice to record all the clinical contact a client has, regardless of who provided it. CPs should be trained to properly record notes and respect the confidentiality of all medical records. If CPs misuse medical records, they should be held accountable, like all other employees.

What will the consumer providers' training consist of?

There are different ideas about what CP training should look like, especially in terms of how much training is required before the job starts, and where training should be provided.

Some of the key content that might be covered in training falls into two main areas:

1. Training on relevant topics:
    - stages in the recovery process
    - the impact of diagnosis on one's self-image
    - mental illnesses: course, symptoms, treatments
    - substance abuse: course, symptoms, treatments
    - self-help and mutual support groups
    - boundaries (how to maintain appropriate "distance" from clients—e.g., not engaging in financial or sexual relationships)
    - dual relationships (how to avoid or, if unavoidable, how to navigate having multiple relationships with the same persons—e.g., being both a provider and a friend; being both colleague and service recipient)
    - confidentiality
    - cultural competency
    - ethics.

"We have monthly trainings, which are regular meetings where people make their orientation trainings concrete. We work on group facilitation, redefining crisis. We always ask: How do we get to the end goal we want without making the decision for the client?" (Expert)

2. Training on relevant skills and knowledge for the job and the setting:

- using one's recovery story
- the role of peer support in the recovery process
- advocacy for recovery environments
- creating relationships that promote recovery
- beliefs and values that promote and support recovery
- effective listening and asking questions
- using dissatisfaction as an avenue for change
- combating negative self-talk
- conducting problem-solving
- the role of spirituality in recovery
- navigating power, conflict, and integrity in the workplace
- developing and pursuing recovery goals
- the basics of medical record documentation
- crisis procedures.

"The position determines what the person needs in terms of training, not just the title of [CP]. Your roles are different depending on what job you're doing. You need training to support that job, whether you are a [CP] or not." (CP)

Also, most agree that training should be tailored, to whatever extent possible, to the strengths of the individual employee or potential employee; delivered on a regular basis, not just at the beginning of a new hire or new position; and provided at least in part by veteran CPs. Finally, it may also be helpful for the rest of the staff—in addition to the CP—to receive some training on the CP role.

Currently, training for CPs varies widely across the country in breadth, scope, and length, ranging from 30 hours to 28 weeks. One of the most highly regarded training programs is the curriculum developed through the Georgia Peer Support Certification Project. The Georgia program is

a comprehensive, classroom-based, 40-hour, 30-module curriculum covering peer support, psychosocial rehabilitation and recovery, the impact of diagnosis on self-image, effective communication skills, and the basics of documentation. In addition, the Depression and Bipolar Support Alliance (DBSA), which works in collaboration with staff from the Georgia Peer Support Certification Program, provides an on-site, classroom-based, 40-hour training program. Both training programs include an exam that requires a minimum score of 80 percent in order to pass the course. In reviewing the existing programs, it appears that most are at least 40 hours (a useful minimum standard for CP training) and that most include an exam.

Other nationally recognized programs that have trained CPs are Consumer Connections of the Mental Health Association in New Jersey and the META Services Recovery Education Center in Arizona. Katz and Salzer (2006) of the University of Pennsylvania Collaborative on Community Integration summarized the details of 13 CP training programs.

"We all sit down and talk openly about things when something happens that is troubling, because we are all recovering. Our [CPs] have monthly phone calls to make sure they have a network with each other to keep going. What's been going on in your life that's stressful? What's the most difficult thing you are dealing with? It's also important to be walking the walk if we are preaching it." (Expert)

As stated earlier, CPs and their supervisors should pursue continuing education. For example, the U.S. Psychiatric Rehabilitation Association sponsors a national conference and other training opportunities for CPs (see http://www.uspra.org). The DBSA offers continuing-education webinars for staff who supervise CPs.

What will the supervision of the consumer providers look like? Who will do it?

CPs should have the same type of supervision as other staff. A designated CP supervisor might contribute to ongoing differential treatment of CPs. As with other staff, supervision should focus on job performance and job support, rather than clinical support. This focus prevents supervision from becoming a therapy session for the CP, which has happened in some settings.

Supervision could also include discussions about the integration of the CP within the organization and/or clinical team. In other settings, CPs have faced challenges integrating into clinical organizations. Supervision would be an appropriate forum in which to monitor that issue. Also, supervision is a good context in which to monitor whether CPs are performing only the duties to which they were assigned. Even when CP jobs are well specified (and especially when they are not), CPs are often given more and more tasks, some of which may be outside their expertise or job description.

Research has shown that some clinicians are skeptical about the contribution CPs can make. This skepticism should be addressed, as it is essential for supervisors to have a positive view of CPs. As mentioned previously, it helps if staff receive some training before CPs are hired; this training helps supervisors as well. Finally, hiring CPs often challenges the norms surrounding traditional clinical care with regard to boundaries, confidentiality, and dual relationships. Supervisors of CPs should be well grounded in these issues to handle these challenges.

Where will the consumer providers continue to get treatment? Are alternative arrangements needed for CPs currently receiving treatment in the facility where they were hired?

"I think it's stigmatizing that we begin looking at peer support people as a separate group of employees. I don't think someone should be a [CP] if they don't have some [counseling] they participate in outside of the place where they offer services." (Expert)

It is not uncommon for CPs to receive ongoing treatment while serving in their CP role. It is always preferable for CPs to receive treatment in another facility in order to minimize the difficulties caused by dual relationships. Therefore, it is recommended that if an individual is hired to be a CP on his or her current treatment team, the CP should make arrangements to receive treatment elsewhere if possible.

How will the performance of the consumer providers be evaluated?

The performance of CPs should be evaluated just like that of all other employees. For example, CPs should be evaluated

according to the same schedule as other employees and evaluations should be limited to job performance, as with all other employees' evaluations. While there are certain aspects of a CP's job performance that overlap with other providers (e.g., maintaining professional relationships co-workers, supervisors, and clients), the evaluation should also be tailored to the specifics of the unique role that CPs play. For example, common CP responsibilities include wellness planning with clients and facilitating peer support groups. A CP's evaluation should include how well he or she accomplishes these activities.

In addition, it is commonplace for employees to rate themselves according to the same standardized criteria used by employers. The employer reviews this self-appraisal, which then becomes part of the overall evaluation process.

How will illnesses of all types be addressed?

At some point, all employees get sick to the point that they cannot perform their duties adequately and need to take time off. Although psychiatric relapse is not common, it does happen. In fact, symptoms associated with mental illness are already a significant cause of sick days for many employees, not just CPs. If a CP becomes symptomatic to the point that he or she cannot perform the job, sick time should be taken. However, CPs should not be expected to take any more or less sick time than any other employee. As in other jobs, it is not the role of the supervisor to determine whether the CP is starting to become symptomatic. However, pointing out behaviors that may be of concern can be useful if handled tactfully. For example, supervisors would not diagnose a bad cough, but they may tactfully suggest getting an examination if an employee was ignoring the problem. Finally, CPs, like other employees, need to know that they can return to their jobs when they are well enough to perform their duties satisfactorily. Like all other employees, CPs should be informed of the organization's policy on extended sick leave.

What will be the policy for fraternization with clients?

Dual-relationship circumstances, i.e., CPs' preexisting peer relationships with clients and new staff-client relationships, are common and are sometimes challenging. There are no standard policies. Practices have ranged from requiring the CP to sever all relationships with clients in the system to allowing these relationships but requiring that they not be romantic or financial to minimize the possibility of exploitation. The key to addressing issues of fraternization is to have clear, well-communicated policies that are consistent with ethical standards, reliably enforced, and locally developed with input from multiple stakeholders.

Best Practices in Implementing Consumer Provider Initiatives

The following suggestions are offered for best practices regarding CP programs.

Transitioning from Client to Consumer Provider

Particularly when a CP becomes a staff member in a community in which he or she has been a client, issues around transitioning can be challenging for the new CP and his or her former peers. It often takes time for CPs to feel like staff, especially if they are working in an organization in which they used to be clients. Supportive supervision and clear job descriptions can help CPs make this transition.

Depending on the recruitment and hiring process, some clients may resent the individual who gets hired as a CP. Clients may have unrealistic expectations of what the CP could do for them, especially if they are friends. Some may also have fears about their confidentiality. Dual roles can also be challenging from the other direction—such as when CPs are working on teams with their former or current psychiatrist or social worker. Participants agreed that once an individual is on staff, he or she should receive his or her own mental

health services in a different facility whenever possible. Even in rural areas where other facilities may not be available, it is not advisable for a CP to receive treatment from his or her employer.

Peer Support Among Consumer Providers

Some form of peer support among CPs themselves can be critical to the success of a CP program, especially if there are several CPs within one organization. The nature and structure of this peer support will likely vary according to the needs and wishes of the CPs on staff at any given time. Some CPs may decide that they want to form a group that meets regularly, for example. Topics covered in the group meetings could include transitioning from client to CP, integrating into clinical teams, relating to colleagues, or other issues.

Some CPs may want a completely peer-led group, for example, while others may want a group that is facilitated by an outside, trusted staff member. Another option is online peer support groups. The advantage of online peer support is that the CP can maintain anonymity while engaging in peer support. Regardless of the arrangement, ongoing peer support groups can provide a forum for discussion of issues and for mutual strength-building. Of course, participation in a peer support group should be voluntary. Also, it might be that all staff could benefit from participating in relevant peer support groups in which they could discuss issues related to their jobs in an open, supportive environment.

Integration of Consumer Providers into Staff Culture

CPs have had mixed initial experiences in their new roles. Some CPs felt welcomed, supported, and included from the beginning of their employment. Other CPs said that role fuzziness and anticipatory anxieties led to a period of trying to find one's niche or needing to figure out and demonstrate one's value to the team and program. Adding to these anxieties, sometimes staff fear that CPs will "take away" their

clients, or staff openly express concern about a CP's stability. Introduction into a team is often more stressful if there is only one CP on the team or in the facility. It would be much easier if there were CP colleagues on the team or at least in the same facility, so the new CP would be less isolated and would have someone with whom to compare notes and exchange support and encouragement.

There are several actions that help new CPs integrate into staff culture. CPs should be expected to participate in all team events—for example, treatment planning meetings, rounds, and other staff meetings. Also, having CPs enter clinical notes into the medical records helps to integrate them within the team. CPs should be allowed to drive team vehicles. All of these actions are important to the CPs' integration because they can help the team meet its obligations more easily. For example, certain teams may not get reimbursed for CP services or get credit for the CPs' hours without documentation in the medical record.

Another helpful strategy is to cultivate an influential staff person or manager to be a CP "champion," with the responsibility of overseeing the incorporation of CPs into the workforce as an important principle of recovery-oriented services. This person could lead a small committee with the same goal. The idea is that making the incorporation of CPs a priority in this way—with actual staff resources devoted to monitoring progress—will improve the chances of success.

"People should take care of their own needs. They shouldn't have their bosses decide [whether] they need a support group. How can we expect [CPs] to help others take care of themselves if we don't give them the space to do that for themselves?" (Expert)

One potential challenge in the integration process is when CPs abandon their mental health consumer identities completely and take on provider roles. This defeats the purpose of having CPs who serve as role models and use their experiences as resources. Supervision will be important in looking out for this and addressing it if it does seem to be occurring.

Opportunities for Consumer Provider Management Roles

In addition to hiring CPs to provide direct services, it is also helpful to have consumers in management roles. CPs should be aware of the career ladder they can climb. CPs in management roles can confer similar benefits to an organization that CPs confer to individual clients. For example, consumer managers are role models who embody the possibility that individuals with mental illness can move up in organizations and are not just being hired as tokens. Their points of view, based on their experience using mental health services, can inform management decisions that may lead to more recovery-oriented care. Movement into managerial positions also demonstrates that the organization is dedicated to the advancement of consumers. As with CPs and all employees, consumer managers need to be able to do the job and should have access to tools of the job (e.g., meetings, resources).

"When we do staff meetings, [CPs] are here. They always bring something to the table that is very valuable. When we interview new staff, we interview as a team. The [CPs] are here." (Administrator)

Addressing Staff Concerns

Another challenge faced by CPs as they transition into a new staff role is the degree of acceptance they feel from their new colleagues, the other staff on the team. CPs often face skepticism when they first join a team. Training of the existing staff, giving staff a say in the hiring process, and soliciting staff input about the structure of the CP role can assist CPs in being more accepted by their new team. Also, staff hesitance can be minimized when CPs are responsible and assertive in offering their assistance to other team members. Finally, staff resistance can be minimized when supervisors require the same level of accountability from CPs as they do from other staff members.

Barriers That Inhibit Consumer Provider Initiatives

Although CPs have become a recognized and valued cadre of employees, unfortunately, there are still several barriers to their employment. Next, we present three types of barriers: (1) misperceptions about CPs, (2) common concerns of nonconsumer staff, and (3) organizational and structural issues.

Misperceptions About Consumer Providers

Here, we outline a few common misperceptions and respond to them.

CPs cannot work full time, either because of disability insurance or because of the responsibility.

It should not be assumed that CPs cannot work full time. Determination of the work schedule and workload should be tailored to the individual. Some individuals will be able to work full time, while others may prefer not to work full time. Decisions about workload should not be predetermined based on consumer status. CPs should be encouraged to seek financial benefits counseling before taking a CP job to be fully informed about the financial trade-offs. Often, full-time employment will bring in more money than the amount that could be lost in benefits.

CPs cannot fulfill the same roles as providers who are not consumers.

The purpose of having CPs is not to have "extra" people who can run errands and do the work and chores that others would prefer not to do. It should be mentioned, however, that the role of the CP is not exactly the same as that of other team members. For example, CPs usually do not have advanced degrees in psychology (Ph.D.) or psychiatry (M.D.). However, they do have experience as mental health consumers, and this experience makes them uniquely qualified

to provide services and serve as role models in ways that are different from nonconsumer providers. For example, CPs can be quite effective in using their lived experiences to engage those with mental illness into services for the first time. In addition, many who serve those with serious mental illness require special training—training that is not often found in academic degree programs. For example, illness management and recovery (IMR) is an evidence-based curriculum that helps individuals with serious mental illness to develop and attain goals and better manage their illness. CPs are some of the main IMR trainers and are in an ideal position to provide other types of training for mental health consumers and for staff who work with mental health consumers and CPs.

According to staff at Lamp Community, "Relapse has not been as much of an issue as people used to think."

CPs will relapse.

While uncommon, relapse or onset of a new illness is possible for any employee, not just for CPs. Even if a CP does relapse, he or she should be treated just like any other employee who has a serious illness that interferes with job performance. And like other employees, if and when the illness resolves sufficiently, CPs should be allowed to return to work. The persistent misconception that CPs will inevitably relapse should be addressed and dispelled in continuing-education programs for mental health staff.

Common Concerns of Nonconsumer Staff

Nonconsumer staff often have concerns about employing CPs. Given that these staff are important stakeholders, their attitudes are a key determinant in the success or failure of CP programs. Similar to the misperceptions above, we present common concerns of nonconsumer staff and respond to them.

CPs are too fragile to handle the stress of the job.

Similar to the misperception about relapse, nonconsumer staff often talk about job stress as a likely trigger for relapse for CPs. However, relapse is rare, mainly because CPs who

are hired have already demonstrated that they can handle job stress.

CPs cannot handle the administrative demands of the job.

This has been shown not to be the case: CPs are capable of appropriate documentation and paperwork associated with administrative tasks. As with any job, appropriate training will ensure that CPs have competence in this area. Again, CPs who are hired have demonstrated these skills or have demonstrated capacity for the development of these skills.

Given that CPs are not professionals, they will invariably cause harm to clients that the other staff members will have to undo.

Nonconsumer staff have mentioned such potential harms as violations of confidentiality (e.g., looking up friends' medical records), poor suggestions to clients (e.g., that they should discontinue their medications), and the development of dual relationships (e.g., providing services to a current romantic partner or friend). While these problems can occur, they are not unique to CPs, and there are many safeguards in place to prevent them. First, all training programs for CPs cover these issues in detail. Second, if a CP program is properly established, the clinical service to which the CP is assigned should adopt specific policies to address these issues. These policies, and the consequences for violating them, should be made clear to the CP upon hiring. Third, these issues should be brought up regularly in supervision. Fourth, if CPs violate any of these standards, they should be held accountable like any other employee. These safeguards and policies should be applicable to all staff, not just CPs.

"If you find meaning in your job, then the situation isn't as inherently stressful. I think the fit of the person with the job—if this is something they really want to do—will help." (Expert)

Organizational and Structural Issues

Even when staff and management are enthusiastic about hiring CPs, there may be additional barriers posed by human resources personnel. For example, in many organizations, hiring CPs requires the creation of a new job class.

This process, which is sometimes cumbersome, can trigger a variety of questions; for example, what types of experiences can be used to determine rate of pay? How are CP services tracked (e.g., what service codes are CPs allowed to use)? How are CP services billed?

While seemingly daunting, these issues can be and have been addressed. Institutions such as the VA have created a new job class that has been approved by their legal councils. The VA has codes for peer support and allows CP services to be billed. Also, more and more state mental health systems are now allowing CP services to be reimbursed under Medicaid or are swiftly moving in that direction (e.g., Georgia, South Carolina, Hawaii, Michigan, Iowa, Massachusetts, Connecticut, Mississippi, Nebraska, Wyoming, Pennsylvania).

Discussion and Summary

We have laid out the benefits of having CPs on staff, some common barriers to hiring CPs, and the components of a CP program. The information contained in this booklet was derived from the experiences and perceptions of people who have worked with, worked as, or observed CPs; literature on the topic; and national experts in this area.

One overriding message is that CPs should not be treated as one "group," with the assumption that all CPs have the same needs and/or abilities just because they are all mental health consumers. A "one-size-fits-all" approach to training or working with CPs is not appropriate.

Another important message is that CPs should be treated like all other employees, while allowing for reasonable accommodation for their illness. This means that CPs should not be excluded from any part of the job of providing services (e.g., team meetings). It also means that concrete expectations need to be presented to CPs, and if they cannot meet these expectations, even with reasonable accommodations, they should be held accountable.

Finally, developing a "culture" that is supportive of CPs should mean more than hiring and training one or two qualified individuals. Developing that type of culture requires a philosophical commitment that can also translate into care that is more client- and recovery-oriented throughout the whole organization.

Further Reading

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