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ORIGINAL PAPER

Developing Strategies to Integrate Peer Providers into the Staff of Mental Health Agencies

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Abstract This study informs new strategies that promote integration of peer providers into the staff of social service agencies. Executive directors, human resource managers, supervisors and co-workers at 27 agencies in New York City were interviewed in-depth. Focus groups with peers were conducted. Consistent with previous research, respondents identified attitudes toward recovery, role conflict and confusion, lack of policies and practices around confidentiality, poorly defined job structure and lack of support as problems that undermined integration. Emerging from the data are strategies related to human resource policies and practices and workgroup relationships and operations that can improve employment of peer staff.

Keywords Peer providers · Employment · Mental Health

Introduction

Increasingly, mental health agencies are including peer providers (peers) on their staffs in recognition of peers as a valuable component of a recovery oriented, best practice approach to rehabilitation services for people with mental health conditions. Peers are persons with mental health conditions who, though without professional credentials, are employed as service deliverers in the mental health provider system. They are hired as role models, counselors, educators, providers of assistance to meet the needs of daily living, and as advocates to empower people with mental health conditions. The purpose of this paper is to present results of a study that explored workplace strategies to help mental health providers improve integration of peers into their staffs so that peers' important contribution to recovery can best be realized.

Recovery is the emergent perspective guiding service programs and treatment approaches for people with serious persistent mental health conditions (consumers) (Ralph, 2000). From this perspective, the goal of services is to instill hope and to support consumers in making their own decisions as they work towards full integration into the mainstream of everyday life (Anthony, 1993, 2000; Fisher, 2003). From a recovery perspective, a developing standard of treatment includes mutual support and advocacy (New Freedom Commission on Mental Health, 2003; Torrey & Wyzik, 2000). One initiative to meet this treatment standard is consumer provided services. These services have been offered by consumer-run programs, by consumer partnerships in which consumers and traditional staff share oversight of the programs and by consumer employees, or individuals providing specialized services in traditional service settings (Davidson, et al., 1999; Salzer, 2002; Solomon & Draine, 1995). The focus of the present paper is peer employees in traditional settings.

Several randomized control trials have demonstrated the impact of services provided by peer employees on positive client outcomes but the evidence in support of their effectiveness has primarily emerged from descriptive studies (Chinman, Young, Hassell, & Davidson, 2006; Simpson & House, 2005; Solomon & Draine, 1995). Overall, however, the

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weight of the evidence suggests that services provided by consumer employees in traditional settings can be as effective, or more effective than, nonpeer provided services (Davidson, et al., 1999; Deegan, 2003; Clarke et al., 2000; Klien, Cnaan, & Whitecraft,1998; Felton et al., 1995; Kaufman, Schulberg, & Schooler, 1994; Lyons, Cook, Ruth, Karver, & Slag, 1996; Paulson et al., 1999; Solomon & Draine, 1995; Chinman, Rosenheck, Lam, & Davidson, et al., 2000). When hired as part of a service team, peers have been found to make a major contribution to the recovery of people with serious mental health conditions (Armstrong, Korba, & Emard, 1995; Besio & Mahler, 1993; Davidson et al., 1999). Consumers who receive peer provided services have fewer hospitalizations, use fewer crisis services, reduce their substance abuse, and experience improved employment outcomes, social functioning and quality of life when compared to those who receive only professional services (Armstrong et al., 1995; Besio & Mahler, 1993; Klien, Cnaan & Whitecraft, 1998; Felton et al., 1995). Further, peer support can stabilize participation in treatment by helping to counter the sense of loneliness, rejection, discrimination and/or frustration that consumers can feel when dealing with the mental health system (Deegan, 1992; Markowitz, 2001; Solomon, 2004).

At the same time, the peers' individual healing benefits from their helper role (Anthony, 2000; Mowbray, 1997; Schiff, 2004; Solomon,2004). Peers can benefit from the social support they receive from the consumers they serve and their nonpeer co-workers, from the experience of helping others identify and resolve problems, and from interacting with other peers who successfully cope with their mental health conditions (Armstrong, et al., 1995; Corrigan & Phelan, 2004; Gates, Akabas, & Oran-Sabia, 1998; Mowbray,1997 ; Davidson, et al., 1999). Finally, peers benefit from the self-sufficiency due to increased income and a sense of self-efficacy and purpose to life that work brings (Akabas & Kurzman, 2005).

Adding peers to the staff of traditional social service agencies, however, has not gone unchallenged. The experience of peers is similar to that of paraprofessional social service workers of the 1960s and 1970s. Initially, using paraprofessionals was heralded as an effective way to provide services appropriate to the culture and expectation of community residents (Alley & Blanton, 1976; Pickett, 1984). By 1970, however, conflicts with professional staff, disillusionment over the poor salaries, lack of job security, and lack of promotion potential undermined the ability of paraprofessionals to work effectively and led to the demise of their use despite their ability to enhance quality of services (Delworth, 1974; Field & Gatewood, 1976; Kurzman, 1990; Pearl, 1974).

Current efforts to employ peers in traditional social service agencies are on the same track. Despite the policy shift to a recovery perspective, many agencies face challenges in translating the recovery approach into practice (Akabas, 1994; Anthony, 2000; Besio & Mahler, 1993; Fisk, Rowe, Brooks, & Gildersleeve, 2000; Chinman, Young, Hassell, & Davidson, 2006; Jonikas, Solomon & Cook, 1997; Mowbray, 1997; Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005). There is evidence that many agencies fail to implement changes necessary to operationalize the recovery perspective and are often indifferent or hostile to peer presence (Carlson, Rapp, & McDiarmid, 2001; Davidson, Weingarten, Steiner, Stayner, & Hoge, 1997; Dixon, Krauss, & Lehman, 1994; Manning & Suire, 1996; Mowbray, 1997; Mowbray, et al., 1996; Vandergang, 1996).

Specific problems that interfere with peer integration include:

1) *Attitudes toward recovery among nonpeer staff*. Stigma persists among many social service providers who continue to believe that recovery is not possible for consumers (Besio & Mahler, 1993; Davidson, et al., 1999; Fisk et al., 2000; Manning & Suire, 1996).
2) *Role conflict and confusion*. Peers are asked to combine their experiences as consumers with providing service and/or are both recipients and providers of service (Dixon, et al., 1994; Miya, Wilbur, Crocker, & Compton, 1997; Mowbray, et al., 1996; Salzer & Shear, 2002). They are uncertain of the boundaries between being a consumer and an employee or of being a friend to fellow consumers and being their service provider (Dixon, et al., 1994). Nonpeer staff is conflicted when they play the dual roles of therapist and co-worker (Carlson, et al., 2001; Paulson, et al., 1999).
3) *Lack of clarity around confidentiality*. Issues arise with respect to disclosure of personal information by peers to others and disclosure of confidential information to agency staff by the peers about consumers that they serve (Carlson, et al., 2001; Fisk, et al., 2000; Salzer, 1997).
4) *Poorly defined peer jobs*. Lack of job descriptions, unequal wages and benefits, low pay, lack of supervision or training, and poor communication are among the structural factors identified as affecting peer integration into the staff (Dixon, et al., 1994; Manning & Suire, 1996; Mowbray, 1997).

5) *Lack of opportunities for networking and support*. People with severe mental illnesses have restricted social support networks (Sarason, Sarason, & Pierce, 1990; Furukawa, Harai, Hirai, Kitamura, & Takahashi, 1999), however, social support has been demonstrated as having a positive impact on recovery in both formal research (Corrigan & Phelan, 2004) and in personal accounts (Fisher, 2003; Deegan, 2003; Steele & Berman, 2001).

The present study responds to the question of what policies, procedures and structures can be provided to support the contribution of peers to the mental health service system. Without such an understanding, effective solutions to the problems cannot be determined and social service providers remain less successful as employers of peers.

Methodology

Based on an intervention research paradigm, the study was designed as the first step in the development of strategies to promote peer integration using a qualitative, multi-method approach (Rothman & Thomas, 1994; Hohmann & Shear, 2003; Rothman & Tumblin, 1994; Comer, Meier, & Galinsky, 2004; Huxham & Vangen, 2003; Zwerling, Whitten, Davis, & Sprince, 1997). Its goal was to generate an in-depth understanding of the circumstances that allow peers to be effective in their designated roles, and experience improved integration into the organization. With this understanding it becomes possible to inductively generate strategies to promote integration. As will be seen in the discussion which follows, these strategies involve human resource policy and practices, work group relationships and division of labor.

Agency Sample

A pool of 117 social service agencies that provided mental health services in New York City was generated from a list of agencies who received funding from the New York City Department of Health and Mental Hygiene in 2003 and/or agencies that hired graduates of Howie the Harp Advocacy Center, a program that offers training to peers in New York City. The only criterion for inclusion was that the agency provided mental health services. Forty-six agencies were randomly selected from the list and asked to participate in the study and 27 agreed. Of those that participated, 18 employed peers, 4 had never employed peers and 5 had employed peers in the past but none were currently on staff. Agencies currently without peers on staff were included to differentiate issues generally experienced by employees of social service agencies from those that were a function of peer status.

At each agency, interviews were conducted with the executive director (or his or her designee), the individual in charge of recruitment and hire (HR representative), a supervisor and a line staff person in the identified supervisor's unit. At agencies where there was a peer on staff, the supervisor and line staff person were from the peer's work group. A total of 93 staff were interviewed (27 executive directors, 18 HR representatives, 22 supervisors and 26 line staff). The total is shy of the expected 108 because some staff held multiple roles or an individual declined to participate and selection of an alternative staff person was not possible. Table 1 summarizes the characteristics of the participating agencies.

Peer Sample

Peers who received pre-employment training through the Howie the Harp Peer Advocacy Center were invited to attend a focus group to discuss their employment experiences at their current jobs. Fifteen peers volunteered to attend one of two focus groups.

Data Collection

Separate sets of semi-structured telephone interviews were developed for peer and nonpeer agencies. Each set included an interview for the four respondent categories: executive director, HR representative, supervisor, and line staff. Thus, there were a total of eight interview instruments. All interviews covered similar content but were tailored to be appropriate to the respondent's agency role. Questions asked about recruitment and hiring policies and disability management initiatives (including training, career development opportunities and accommodation practices). In

Table 1 Characteristics of Participating Agencies

Agency Characteristic	Peer Agencies (n = 18)	Nonpeer-never peer Agencies (n = 5)	Nonpeer/peer in the past Agencies (n = 4)
Offer services in teams	100%	100%	100%
Multi-site	72%	100%	100%
Multi-service	50%	60%	100%
Employ consumers in other capacities	67%	40%	75%

addition, respondents at agencies with peers or peers in the past were asked about operations and policies specific to peer employees including: (1) peer recruitment, the number of peers hired, the job titles peers have filled, the peers' job tasks and responsibilities, and whether work was full time or part time, temporary or permanent, (2) supervision for peers and the support provided such as training, accommodation, or mentors, and (3) issues of confidentiality, disclosure, role conflict, work overload, or role ambiguity. Questions were not asked with respect to individual peers, and peers at each agency remained anonymous to the researchers. On average, interviews lasted one hour. The interviewer took written notes during the interview to record responses.

Recruitment began in January 2004 and was completed in September 2004. Executive directors were called by the researchers and invited to participate in the study. If they consented, they provided the names of the HR representative, a supervisor (with a peer among his/her supervisees if a peer agency) and a coworker in the same workgroup as the supervisor (currently working with peers if a peer agency). These individuals were invited to participate in the project. Participation was completely voluntary. Four interviewers (three study coordinators and one second year social work Masters student intern) were trained by the co-principal investigator to conduct the interviews.

Peers attending the focus groups were asked how they secured their jobs, what their jobs involved, what they perceived as an ideal peer job, how disclosure occurred, how they felt about their co-workers and the way they were treated, and what they would change. The 90 minute sessions, facilitated by the co-principal investigators, began with completion of an informed consent form which explained the study purpose and requested participants' commitment to maintain confidentiality of the group discussion.

All study instruments and procedures were reviewed and approved by the Columbia University Institutional Review Board.

Data Analysis

The data analysis was guided by an inductive approach that identified themes and patterns across interviews (Strauss & Corbin, 1990; Miles & Huberman, 1994). Interview notes were transcribed into a database. An iterative process was then used by the study team to develop a coding scheme. The process began by randomly selecting an agency and reviewing the set of interviews from that agency. Independently, each team member identified categories of information. The team included the co-principal investigator, two study coordinators, a research assistant (who was also an individual with a mental health condition) and a second year social work Masters student intern.

The team met to combine the lists of codes and to come to consensus on their definitions. Using the combined list, team members repeated the process of independently coding a second set of interviews, and meeting to assess intercoder consistency in the application of the codes and to discuss new codes that emerged. This process was repeated two additional times. At this point no new codes emerged and there was consensus among the group on the meaning and application of the codes. The codes and their definitions were then formalized.

The final list contained 22 codes. One code pertains to individual characteristics of the peers (e.g., mental health diagnosis, cultural background, previous training or education). Four codes describe the peer position (job title, job structure, role, and required qualifications for hire.) Ten codes characterize agency operations and policies (agency mission, agency policies and practices around disclosure, accommodation, benefits, promotion, performance appraisal, supervision, recruitment and hire, orientation, and training and staff development.) Three codes pertain to information about policy and practices specifically for peers (sharing information between peer and nonpeer staff, peer supervision and training targeted to peers). Four codes are related to agency stance toward the employment of people with mental health conditions in general, and peers in particular (perceptions and attitudes toward peers, lack of understanding of the peer position, reasons for hiring the peer and the employment of people with mental health conditions or other at risk factors such as criminal history or substance abuse history at the agency.) Finally, the last code marks strategies that interview respondents identified helped to integrate peers into the staff.

Using the 22 codes, two team members applied the codes to the remaining interviews. The coders met regularly with other team members to modify the coding scheme or code definitions as necessary.

Finally, all information with the same codes were pulled into reports using Atlas-ti and each report assessed for differing or convergent points of view. Reports were then compared to determine where there was redundant information or connections among them. Consistent with other research and experience four major themes emerged from the cross-report analysis: (1) attitudes toward peer providers, (2) role conflict and confusion, (3) lack of policies and practices around confidentiality, and (4) lack of support (Salzer,

2002; Solomon, Jonikas, Cook, & Kerouzc, 1998). These four themes provide the organization for reporting the results.

Results

Attitudes Toward Peer Providers

Current study findings showed that among some agency staff there is a persistence of stigma with respect to the capacity for people with mental health conditions to work in general and the importance of the peer role in particular. Some respondents voiced the belief that having a mental health condition, by definition, meant that the individual was 'sick' and, therefore, unable to give 100% performance in the workplace. They believed that peers were 'cheap' labor who were unable to deal with the stress of working, whose presence on staff had the effect of 'dumbing down' professional staff, who were unreliable, who could not go beyond their own perspectives, and who could not respond to emergency situations.

Others, however, felt that peers ''made the concept of recovery real'' and they were ''a living, breathing reminder that staff's work works!'' They believed that peers enhanced the quality of service, helped staff understand clients, increased client satisfaction, increased staff morale, facilitated communication, empowered both clients and staff, and improved the status of the agency in the community.

Positive attitudes towards peers appeared to be related to the extent to which respondents made the connection between peers on staff and the agency mission to promote recovery. ''Having a peer on staff is consistent with our mission. It gives a good message to our clients. The organization is putting its money where its mouth is. The peer offers a different type of relationship to consumers.'' ''Peers enrich the lives of clients and facilitate the transition to independence, the same as our mission.''

Some staff recognized the connection between agency mission to empower consumers and the employment of peers:

> It has been a long time in coming. Since the mid-80's the agency has been involved in the consumer movement and struggled to see how they could be more inclusive of consumers. They wanted to employ them in order to legitimize the work they were already doing in running groups or volunteering in advocacy.

Conversely, peers were considered expendable when seen as peripheral or unrelated to the agency mission. One respondent from an agency that no longer hired peers commented, ''Having a peer specialist is an enhancement to the program. However, it was an enhancement we could not afford.''

Others felt that the peer contribution was unimportant because it did not contribute to the agency's bottom line or to the performance measures upon which the agency was evaluated. One executive noted that the agency focus was on maintaining contracted levels of service. Peers did not contribute to service statistics and, therefore, were irrelevant. Another commented, ''Peers can't generate revenue.''

Finally, for some, the value of peers was minimized when the reason for hire was externally motivated rather than driven by the agency's mission. ''The funder requested that we have a peer for the program. With an ACT team, the funder tells us what positions we should hire for....''

Role Conflict and Confusion

Role conflict and confusion was multi-faceted and often caused a breakdown in the ability of peer and nonpeer staff to communicate and work together. A frequent confusion for nonpeer staff was between their role as co-workers and that of clinicians. As one respondent commented, supervisors and co-workers would often 'go clinical' in response to a peer's problem. A peer provider explained, ''Some of the psychiatrists and therapists try to therapize me. I stay in my role but other staff don't stay in their roles. They become overly concerned that I'm becoming symptomatic, [that they need to] give me meds.''

Nonpeer staff often had difficulty separating mental health issues from work-related issues with regard to peers. For example, when a peer mentioned to a co-worker that he found the enormous amounts of paperwork stressful and asked for advice on how to manage it, the co-worker responded by asking him about his medication compliance. Several supervisors offered their experience. ''If a peer calls in sick there is always a question is this about mental health? I am not used to wondering what's wrong if another staff member calls in sick.'' Another observes, ''I will get a phone call from a worker about a peer and the problem isn't really about being a peer at all but just a typical employee problem that the worker is blaming on peer status.''

Role conflict and confusion also occurred when peers were both friend and service provider to clients. In this instance, nonpeer staff tended to view the

methods peers used to connect with clients as unprofessional. ''Peers need to be more polished, think about issues of consumers more systematically and knowledgeably. They need to be more professional, less casual.'' ''Because they want to help the consumers, the peer sometimes involves his or her own personal feelings, but it is not done in a professional manner.''

Factors that appeared to reduce role conflict and confusion included how agencies implemented recruitment strategies for the peer position, how they applied policies related to staff/client relationships, how they defined and operationalized the peer role, and how they provided understanding of the peer role through training.

Peer Recruitment

Role confusion arose frequently when agencies recruited peers from within their client population, especially when there were pre-existing personal relationships between peers and clients or staff.

> In another [unit] it was too difficult for the peer. He had been close friends with some of the consumers before and it was too difficult to cut off friendships. He would have consumers over to his apartment for drinks. His case manager was still on staff. I think there were times when he needed help but didn't ask for it because he was now employed by the place where he had received services. It was his major support network in terms of receiving services and now it was his job and his workplace. This was a big problem.

Recognizing the problems caused by hiring from within, some agencies established policies to not hire internally and developed arrangements to hire from other providers. ''What we do now is that we have agreements with other agencies to hire their consumers as peer providers and they hire our consumers.''

Policies Related to Staff/Client Relationships

Respondents expressed how role confusion was perpetuated by contradictory or unclear policies and practices, particularly governing staff/client relationships. For example, at some agencies, peers were not expected to abide by the same policies as nonpeer staff. Nonpeer staff perceived this as a double standard, reinforcing a sense of difference between peer and nonpeer staff. Peers, lacking experience with the world of work, often did not understand the policy or the implications of abiding by it. A supervisor commented, ''We had a peer that was dating a consumer in our agency. They were dating before he had been hired as a peer. We thought as long as they were discreet, it would be okay.'' Another observed:

> Professional staff is expected to maintain boundaries. Social workers relate to clients as caretakers and are expected to maintain a professional relationship with clients in line with professional ethics and standards. For peers, it is perfectly acceptable to socialize with consumers. For the peers, where is the abuse if they form personal relationships with the clients? In this context, peer conflict is really reduced. If peers choose to engage in financial or sexual relationships with a client, the burden is on the peer. Peers are not caretakers. If they aren't able to develop personal relationships with clients, it undercuts their work.

Poorly Defined Jobs

Role conflict and confusion resulted from poorly defined or poorly operationalized job tasks. When asked to list the peers' job tasks, respondents generated an extensive array of responsibilities from 'pitch in wherever needed' to lobbying and counseling (see Table 2). Comparison of written peer job descriptions (provided by the HR representative or supervisor) with the list of tasks that respondents actually performed showed that the expectations of peers were often unreasonable and greatly exceeded the formal specified job responsibilities. A supervisor recognized the fallout of this. ''Peers have a flooding of tasks and they get overwhelmed. There are too many tasks for peers...''

In addition, some viewed peer tasks as distinct from other staff roles while others did not. When peer tasks overlapped those of nonpeer staff, it left both peer and nonpeer staff confused about their roles. It also led some nonpeer staff to express concern and resentment toward peers. Nonpeer staff felt that peers placed nonpeer jobs in jeopardy by fulfilling the same roles but were 'cheap labor.' Peers felt confused because the unique contribution they could make was lost.

Inadequate Training and Lack of Communication

Role confusion and conflict appeared to occur when agencies did not prepare nonpeer staff for the inclusion of a peer colleague. They were not provided with training on issues around working with someone with a

Table 2 List of Possible Peer Job Tasks

Support to Clients
Help clients with budgeting and ADL
Help clients with entitlements
Plan social activities for clients
Provide job coaching
Provide vocational counseling
Complete intake assessments
Identify resources for clients
Escort clients on outings or to appointments
Act as an advocate for clients
Problem solve with clients
Provide discharge planning
Communicate with collaterals/ family members of clients
Facilitate groups
Co-facilitate MICA groups
Support to Other Staff
Assist case managers with caseloads
Prepare presentations for other staff
Participate in meetings
Provide information to staff about what clients want or need
Provide feedback to other staff regarding clients
Administrative and Non-Specific Tasks
Take responsibility for a clubhouse unit
Put together a resource manual
Document interactions in case notes
Set up facilities for meetings
Pitch in whenever needed
Answer phones and keep statistics
Greet and register clients
Community Outreach
Lobby in Albany (state capital)
Market agency programs in the community
Make presentations

mental health condition or the expectations for the peer at the agency. When asked about what types of training were provided to staff and management, few mentioned training around the Americans with Disabilities Act, accommodation, or mental health issues. Some voiced the opinion that training was not needed. ''They are clinicians and they should know how to and be able to relate to the peer.'' Others, however, recognized the need. ''I think the staff needs more training around working with peers, regarding stigma and working with someone who has a mental health condition. The peers don't feel as connected to the staff.''

Clients were rarely provided with an understanding of the peer role through training. If the peer was also a friend, clients did not understand how their relationship to the peer needed to change once the peer assumed provider status. ''Some clients remember when the Peer Advocate used to be a client and they get jealous because she has moved on and has a job. They think of her as a client, like themselves, and not staff.'' ''One of my consumers, for whatever reason, felt that because I am a recovering addict that I couldn't help her because she has never been addicted, only a mental health consumer – she got very horrible to me – I am having problems...''

Finally, the peers themselves were not provided training on workplace policies and practices and how they applied to their position. Several agencies hired peers who had graduated from a formal peer training program but few were offered training once employed. Several supervisors observed, ''Where is the time and resources to have this training you talked about? The peer is 1 employee out of 60, I can't make that kind of investment for one employee when the other 60 need so much.'' ''Peers don't have the education. We have to provide services. We can't be going to training and meetings all the time.''

A comment by a peer, however, highlights the challenges they faced without formal training on job expectations:

> We all have certain things that we are supposed to do but I can't get a job description ... I don't want to complain. A lot of responsibility is thrown on me and I need it and want to advance but it is unstructured. All of a sudden my supervisors gave me a two minute lesson on how to do someone's treatment plan and baseline assessment.

Agencies spanned the spectrum on how they helped new hires enter the workplace. At one end of the spectrum a formal orientation was offered to all new employees over several days and every new employee was assigned a mentor to assist with learning about the job and the agency. At the other end of the spectrum, new employees were, at best, asked to read a policy and procedures manual. Learning the job was a matter of trial and error.

Peers were usually offered the same orientation as nonpeer staff. In some cases, however, respondents recognized that the hiring process was a key point of transition for peers from being a consumer to a provider of services. A supervisor observes, ''There is a transition that peers go through when they start the job. They need support. They transition from consumer to colleague. For example, they need to transition from calling me Ms. [X] to calling me by my first name.''

Some respondents believed that the ability to make the transition was the peers' responsibility and the agency did not have a role in supporting the shift. Other respondents perceived the conflict between peer and nonpeer staff to be greatest at the time of transition and believed that extra support, training, and supervision were needed to ensure peers' smooth shift into the provider role.

Lack of Clarity Around Confidentiality

Respondents identified several dimensions of confidentiality that affected peer integration. These included the peers' right to control disclosure of their peer status, the nonpeer staff perception that client records should not be shared with peers and the peer staff perception that the client information to which they were privy should not be shared with nonpeer staff.

Disclosure of Peer Status

The disclosure of the peer status was perceived as a key factor affecting peer integration. Respondents pointed to the labeling of the position as a major issue. Among the 18 agencies that have peers on staff currently, there were 16 different job titles. The titles fell into two categories, those that identified the peers (e.g., Peer Specialist, Peer Advocate) and those that were generic (e.g., Staff Generalist, Program Aide). In unionized settings titles were set by the union and were generic. In non-unionized settings titles varied and were determined most often by the HR department or the supervisor. They frequently based their selection on agency convention (e.g., all entry level staff had the same title) or in response to external regulation or funding (e.g., the expectation that Assertive Community Treatment (ACT) teams have a peer member or state funding for a peer specialist position).

Respondents tended to feel that titles that disclosed the peer status set peers apart from nonpeer staff and rob peers of control over the disclosure of their status. One observed, ''We used the term 'peer advocate' but changed it to 'client advocate' so the peer could choose when to self-disclose.'' This created a dilemma. Peers were hired because of their mental health status and expected to use their experiences with the mental health system in completing job tasks but revealing their peer status was stigmatizing. One peer commented:

> Can't you advocate for a person no matter what the title is? If I am a person, it doesn't matter what the title is. I have coworkers who jump whenever they hear 'peer' or 'forensic.' I don't have to go into a long story about my life. I can advocate without a title but if I go to society or tell you what I did you will slam the door in my face.

Exploring this dilemma with respondents revealed that misperceptions about peers often resulted from the belief that the title carried an adequate disclosure. Agencies tended not to have formal policies or procedures for peers to manage and control the disclosure of information about their mental health status. It was assumed that the peer title conveyed what co-workers should know. But, as one peer commented, ''If you are a Peer Specialist disclosure is automatic – lets people know you are a consumer. But what you've been through they do not know.''

Co-workers, for example, were rarely provided a formal introduction to the peer role and peers were not given the opportunity to determine to whom to disclose, when to disclose and what information to share. As a result, staff had a misunderstanding of the peer role and the ability of the peer to join the staff as a productive worker.

A second way that peers struggled to control disclosure of their peer status was when they received mental health services at the employing agency and no provisions were made to ensure that their records were kept confidential. In these instances, the mental health issues of the peer were open to anyone who had access to the records. Like the issue raised by the job title, open records led to a lack of control over disclosure and perpetuated the role of peer as client rather than as colleague.

In anticipation of this problem, some agencies implemented the policy that the records of peers recruited internally were kept confidential in the same way medical records were maintained for all staff and, once hired, peers were required to receive services elsewhere.

Peer Access to Client Records

Many agencies maintained the policy that peers should not have access to client records. This was motivated by either the actual experience of broken confidentiality by the peer, the fear that peers would be unable to abide by confidentiality policies or that the peer position did not need access to this information. ''The agency does have a policy in which the peer advocate does not have access to client records. It is not pertinent for the person in the peer position to have access.''

The consequence of this stance was frequent miscommunication between peer and nonpeer staff about the goals of treatment, and reduced the potential contribution of peers, often at the expense of the care to the consumer. Without access to the record, peers were left in the dark about the overall treatment plan for the consumers they served. For example, a supervisor complained that the peer neglected to tell staff when a client had stopped taking medication but the peer felt she was operating true to the recovery

perspective by supporting the client's right to choose whether or not to take medication.

Peers not Sharing Information About the Clients with Nonpeer Staff

Finally, as friends of clients, peers would learn about personal issues that had bearing on the clients' treatment. Often, this information could make an important contribution to understanding clients. ''I got valuable information from the peer on clients. The information would include how to approach consumers, how to treat them, and ideas on engaging with consumers.''

At times, however, peers would choose not to share this information with agency staff because of a sense that they were violating the trust they believed important to their friendship or because of pressure from the client to maintain secrecy as a condition for friendship. For example, one peer provider learned that his roommate, who was a client at the peer's agency, was using drugs but withheld the information from the roommate's counselor because of pressure from the roommate not to tell. ''We had issues with our peers being privy to information that staff didn't have, not the other way around..... Peers feel a sense of disloyalty when sharing this information with staff.''

Job Structure

The peer job structure had the potential to either isolate peers or help to include them in staff operations. Respondents were asked to list the required qualifications for the peer position, job tasks, and the job structure including number of hours of work each week, whether or not the job was permanent, the level of compensation, and union status.

Qualifications for the peer position included a range of credentials. Most agencies required being a current or former recipient of mental health services, possessing a high school diploma or equivalency, and some previous work experience of any kind. Other qualifications included having one year previous advocacy experience, bilingual ability, state clearance for child abuse, excellent communication skills, bachelor's degree, completion of a peer training program, and previous experience working with consumers.

Job qualifications set the tone for how the peer position was received by nonpeer staff. Some agencies viewed the mental health experience comparable to formal credentials. They placed great value on the unique peer perspective and demonstrated recognition of its worth by accepting experience in lieu of educational requirements when peers sought to switch jobs. Other agencies, however, viewed the peer position as a strictly nonprofessional, dead end job.

Peers were often in positions that were part time, temporary, not compensated at the same rate as nonpeer staff in comparable jobs, and without clear performance standards or paths for promotion. The job structure conveyed the message that peers were less valued by the agency and reinforced the rationale for sidelining peers by nonpeer staff. As a consequence, peers were less likely than nonpeer staff to receive supervision, or be given the opportunities for staff development or promotion.

Management believed that the structure of the peer position was responsive to peer needs. For example, some indicated that they made positions part time or paid peers less because peers did not want to affect their cash benefit by working too many hours or earning too much. Peers indicated, however, that they were not offered benefits counseling to make informed decisions about how much to work. Further, working part time frequently excluded peers from access to employer health care or other benefits. Temporary positions were often a function of the availability of external funding. Agencies were not making a commitment to the peer role or choice regardless of funding.

Lack of Opportunities for Networking and Support

Peers, like all workers, need social support in the workplace in order to best meet job requirements and feel satisfied with their jobs (House, 1981). The opportunities for support, as indicated in the preceding discussion, were affected by staff attitudes, role conflict and confusion, issues of confidentiality and job structure. For example, leadership at some agencies believed that all staff should be treated the same regardless of differences among them. ''We try to be consistent with all employees, to do something beyond that would be unfair. We didn't do anything special or different for other employees.'' The result was that peers were not offered additional training, support, or the accommodation to which they are entitled under the Americans with Disabilities Act that would help them adjust to the work world and operate effectively with other staff.

As indicated above, supervision was recognized as an essential source of support for peers. In most agencies peers receive regular supervision but the role confusion was apparent when supervisors described the support they offered to peers. ''I have taken her under my wing. Outside the agency I have been an advocate for her. She is in a situation now where she has lost her

benefits. She looks to me for that type of support.'' ''Also, it was a real struggle for the supervisor having an employee who was someone else's client. It was a problem for the supervisor in terms of what hat to wear.''

Job structure also undermined opportunities for support. For example, when positions were part time, not only were there fewer opportunities for supervision, but also fewer opportunities for peers to participate in agency life such as meetings or social events. In fact, some used the part time status as an excuse for scheduling team meetings when peers were not available. At one agency team meetings were scheduled in the morning but peers only worked in the afternoon. In many agencies where peers were not allowed to participate in team meetings, no other forum for sharing information with the clinical team and receiving feedback on their activities was provided.

Implications for Integration of Peers on Staff

Peers have the potential to make a major contribution to the recovery of consumers receiving services through mental health agencies as well as to experience individual benefit from assuming the helper role. The inability to include peers on staff effectively, however, places at stake the valuable contribution to mutual support and recovery that the peer provider position offers both to peers and to the consumers they serve. Equally important, the influence of the peer on shifting agency culture toward the recovery perspective is at risk.

This qualitative, exploratory study provides insight into some of the practices that create problems with integration of peers on staff as well as some of the workplace strategies that promote effective integration. The exploratory study design limits the generalizability of the findings. Although size and type of social service agency varied, the study reflects the experience of agencies in one geographic area. Their importance, however, lies in intervention development. They inform the development of strategies to help include peers on staff. The effectiveness of these strategies will need to be tested by future research.

Confirming previous research, the study showed that integration of peers on staff was undermined by misperceptions and stigma among nonpeer staff about consumers as workers, role conflict and confusion, inadequate policies and practices around confidentiality, poorly defined job structure, and a lack of opportunities for networking and social support (Chinman, Young, Hassell, & Davidson, 2006; Salzer, 2002). Conversely, peer integration was more successful when leadership created an understanding of the importance of the peer role to agency mission, provided training to peers, nonpeers and consumers that reinforced that commitment, clearly defined peer and nonpeer staff roles and helped all staff understand how to work together effectively, established clear policies and practices around sharing information, recruitment and hire of peers, and ensured effective communication and support through supervision and training (Solmon, Jonikas, Cook, & Kerouzc, 1998). Specific strategies to avoid the problems and promote the successful integration emerge from the data, a review of the literature and the experience of the authors in providing extensive training and consultation to agencies that employ peers (see Table 3). These strategies tend to cluster into two types, (1) human resource (HR) policies and practices or (2) workgroup relationships and operations.

HR policies and practices promote integration in several ways. First, they ensure commitment to peers by recognizing and supporting peers as an essential part of the agency's staffing pattern. Study findings suggest that this commitment can be expressed through (1) hiring policies that are responsive to the unique qualifications of peers such as accepting experience in lieu of formal credentials; (2) a job structure that conveys the importance of peers to the agency. Positions that are permanent and independent of changing levels of funding, compensated and evaluated on the same performance standards as nonpeer staff, and provide opportunities for advancement make it clear that peers are as valuable to the agency as their nonpeer co-workers; (3) HR practices that help peers participate in the workplace to the fullest extent possible. Benefits counseling that prepares peers to make informed decisions about the number of hours to work can help to overcome a frequent barrier to workplace participation; (4) orientation and training to all constituencies (peers, nonpeers, consumers). Better staff functioning will result from clarity around roles and required provisions of the ADA; and (5) clear communication of the value of peers in the mission statement that supports recovery, a strong leadership role in supporting the mission, and formalized opportunities to learn about policies and practices such as a mandatory new employee orientation.

Second, HR policies and practices promote integration by responding to issues of role conflict and confusion. Study findings suggest that policies and practices to minimize conflict and confusion include (1) formal recruitment strategies that specify the labor pool from which peers will be recruited (internal or

Table 3 Workplace Strategies to Respond to Problems and Promote Integration

Factor Affecting Peer Integration	Workplace Strategies that Promote Integration
Attitudes toward recovery	Clear recovery position in mission statement Leadership commitment to recovery well communicated Leadership support of recovery Peer position viewed as essential rather than an add-on
Role conflict and confusion	Well-defined recruitment strategies Consistent application of workplace policies to peer and nonpeer staff Written job descriptions for all staff including peers Supervision to ensure that actual job expectations are the same as written job expectations Training to staff and clients to provide understanding of roles New employees receive formal orientation
Lack of confidentiality	Neutral job titles that do not disclose peer status Implement a formal disclosure process for peers Keep previous treatment records of internally recruited peers in confidential files Do not allow peers to receive services in the units where they are employed Training on policies and practices related to confidentiality Establish a formal process for sharing work-related information between peer and nonpeer staff
Job structure	Accepts experience in lieu of formal credentials as HR policy Peer positions are permanent Peer positions have clear path for promotion Apply the same performance standards to peers and nonpeers Compensate peers and nonpeers equally in comparable positions Provide benefits counseling to help inform the peer's decision on hours to work
Social support	Opportunities for interaction in agency life (team meetings) Include peer input in treatment planning and case notes Offer peers training to learn language of the workplace Supervision Meet ADA requirements for accommodation

external to the employing agency), and if recruited internally, how that should occur. For example, recruitment may be limited to sites or units different from those which have the job opening; (2) clear, well communicated guidelines governing staff/client relationships that are implemented consistently across all staff. For example, if the agency policy is that staff cannot have personal relationships with clients, the policy should apply to peer as well as nonpeer staff. Training is important to communicate the guidelines and prepare nonpeer staff to transition from the role of therapist to colleague, prepare peers to transition from the role of consumer to service provider, and prepare clients to transition in their relationship with the peer from friend to service provider; and (3) job expectations are formalized through written job descriptions so that peer and nonpeer staff understand clearly what each other's job involves.

Third, HR policies and practices promote integration by establishing clear policies and practices around issues of confidentiality. Although HIPAA regulations have changed the way that staff handles client information, the issues around confidentiality for peers do not typically receive the same attention. The findings suggest that HR polices and practices to protect confidentiality might include (1) peer job titles that do not disclose peer status, (2) a formal disclosure process that provides peers with control over when to disclose, to whom to disclose and what information to share, (3) confidential records for peers who were treated at the employing agency prior to hire, and (4) a ban on peers receiving mental health services from the agencies where they are employed. To ensure that these individuals have access to treatment, however, the agency might establish a referral system to other treatment providers.

Along with HR policies, practices and structure, study findings suggest that workgroup strategies that build relationships between peer and nonpeer staff and clarify the division of labor are important to effective peer integration. The emergent strategies focus on establishing clear channels of communication between peer and nonpeer staff to share information related to treatment planning, training on how to communicate effectively, and providing opportunities to increase mutual understanding and support. Thus, workgroup strategies might include (1) formal structures for peer and nonpeer staff to share information such as team

meetings, one-on-one meetings between peer and nonpeer staff, mandatory peer and nonpeer entries in case records, mandatory requirements for peer and nonpeer staff to read the records for all new clients, or opportunities for peers to participate in staff development and training activities, particularly those related to treatment philosophies and approaches; (2) training for peer and nonpeer staff on how to respond to issues around sharing information such as providing staff with an understanding of the importance of the information peers gather about clients to clients' treatment, and offering peers specific ways to explain to clients the conditions under which clients can feel that shared information is protected. Training is also needed for supervisors to ensure that they understand HR policies and practices with respect to confidentiality and role definition and are equipped to set them in place and enforce them among their staff; (3) regular supervision to peer staff to ensure that they are receiving the support and accommodation they need to best meet job requirements and to nonpeer staff to help them separate work issues from mental health issues; and (4) informal occasions to interact such as staff lunches or other social events that help staff develop relationships and mutual understanding.

Finally, the data suggest a process for strategy implementation that includes:

1. *Assess the agency to determine how prepared it is to employ peers*. Integration of peers on staff can represent a significant change in the way an agency operates. Determining agency readiness for change begins with an assessment of the extent to which its mission embraces a recovery perspective, leadership is committed to peers on staff, and HR policies are inclusive and thus supportive of difference among all staff.
2. *Create an understanding among all staff and clients of the peer role and the policies and practices which support the peer contribution to services* through formal orientation for all new hires, supervision that includes education about policies and practices, and training for peer staff about being workers and nonpeer staff and clients about working with peers, and interpreting the importance of peers to the agency mission.
3. *Formalize a recruitment process and job structure for peer positions* to establish the policies, practices and structures to guide the recruitment of peers and define the peer position.
4. *Clarify staff roles* through consistent application of formal guidelines governing client/staff boundaries, explicit policies and practices that determine how information is shared about clients between peer and nonpeer staff and specify a disclosure process that allows peers to control sharing information about themselves.
5. *Provide on-going support to staff to maximize peer inclusion* key to achieving the goal of long term retention of peers on staff including formal channels for communication among staff, regular supervision that includes separating mental health issues from work issues, on-going training and role clarification, opportunities for accommodation and opportunities for peers to share their feelings and develop personal connections with nonpeer staff.

Peers remain vulnerable and their positions remain largely temporary, sensitive to shifts in funding and management philosophy. This places great importance on the need to implement strategies to help agencies develop the capacity to employ peers effectively and help peers overcome organizational barriers to carry out their contributory role. The findings reported here take one important step toward this goal. Ultimately peers, and all other staff, are well served by HR policies and practices that are consistent, fair-minded and reflect managerial commitment to recognizing and valuing the difference among all groups and dealing with those differences in an inclusive, culturally competent manner.

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References

Akabas, S. H. (1994). Workplace responsiveness: Key employer characteristics in support of job maintenance for persons with mental illness. *The Psychosocial Rehabilitation Journal, 17*(3), 91–101

Akabas, S. H. & Kurzman, P. (2005). *Work and the workplace: A resource for innovative policy and practice* New York: Columbia University Press

Alley, S., & Blanton, J. (1976). A study of paraprofessionals in mental health. *Community Mental Health Journal, 12*(2), 151–160

Anthony, W. A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal, 24*(2), 159–168

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11–23

Armstrong, M. L., Korba, A. M., & Emard, R. (1995). Of mutual benefit: The reciprocal relationship between consumer volunteers and the clients they serve. *Psychiatric Rehabilitation Journal, 19*(2), 45–49

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

Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumer-providers: Barriers and alternative solutions. *Community Mental Health Journal, 37*(3), 199–213

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

Chinman, M., Young, A. S., Hassell, J. & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *Journal of Behavioral Health Services & Research, 33* (2), 176–195

Clarke, G. N., Herinckx, H. A., Kinney, R. F., Paulson, P. I., Cutler, D. L., Lewis, K., & Oxman, E. (2000). Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: Findings from a randomized trial of two ACT programs vs. usual care. *Mental Health Services Research, 2*(3),155–164

Comer, E., Meier, A., & Galinsky, M. (2004). Development of innovative group work practice using the intervention research paradigm. *Social Work, 49*(2), 250–260

Corrigan, P. W., & Phelan, S. M. (2004). Social support and recovery in people with serious mental illnesses. *Community Mental Health Journal, 40*(6), 513–523

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K., (1999). Peer support among individuals with severe mental illness: a review of the evidence. *Clinical Psychology; Science and Practice, 6*(2), 165–187

Davidson, L., Weingarten, R., Steiner, J., Stayner, D., & Hoge, M. A. (1997). Integrating prosumers in clinical settings. In C. T. Mowbray, D. P. Moxley, C.A. Jasper, & L. L. Howell (Eds.), *Consumers as providers in psychiatric rehabilitation*(pp 437–455). Columbia, MD: International Association of Psychosocial Rehabilitation Services

Deegan, P. E.(1992). The independent living movement and people with psychiatric disabilities. Taking back control over our own lives. *Psychosocial Rehabilitation Journal, 15*(3), 3–19

Deegan, G. (2003). Discovering recovery. *Psychiatric Rehabilitation Journal, 26*(4), 368–376

Delworth, U. (1974). Paraprofessionals as guerillas: Recommendations for system change. *Personnel and Guidance Journal, 53*, 335–338

Dixon, L., Krauss, N., & Lehman, A. (1994). Consumers as service providers: The promise and the challenge. *Community Mental Health Journal, 30*(6), 615–625

Felton, C. J., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. *Psychiatric Services, 46*(10), 1037–1044

Field, S. H., & Gatewood, R. (1976). The paraprofessional and the organization: Some problems of mutual adjustment. *Personnel and Guidance Journal, 55*, 181–186

Fisher, D. (2003). People are more important than pills in recovery from mental disorder. *Journal of Humanistic Psychology, 43*(2), 65–68

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

Furukawa, T. A., Harai, H., Hirai, T., Kitamura, T., & Takahashi, K. (1999). Social support questionnaire among psychiatric patients with various diagnoses and normal controls. *Social Psychiatry and Psychiatric Epidemiology, 34*(4), 213–222

Gates L. B., Akabas S. H., & Oran-Sabia V. (Winter 1998) Relationship accommodations involving the work group: Improving work prognosis for persons with mental health conditions. *Psychiatric Rehabilitation Journal 21*,(3):264–272

Hohmann, A. A., & Shear, M. K. (2003). Community-based intervention research: Coping with the ''noise'' of real life in study design. *The American Journal of Psychiatry, 159*(2), 201–206

House, J. S. (1981). *Work stress and social support* Reading, MA: Addison-Wesley Publishing Co

Huxham, C., & Vangen, S. (2003). Researching organizational practice through action research: Case studies and design choices. *Organizational Research Methods, 6*(3), 383–403

Jonikas, J. A., Solomon, M. L., & Cook, J. A. (1997). An inclusion framework: Preparing psychosocial rehabilitation programs and staff for the consumer hiring initiative. In C. T. Mowbray, D. P. Moxley, C. A. Japser, & L. L. Howell (Eds.), *Consumers as providers in psychiatric rehabilitation* (pp. 419–436). Columbia, MD: International Association of Psychosocial Rehabilitation Services

Kaufmann, D. L., Schulberg, H. C., & Schooler, N. R. (1994). Self help group participation among people with seer mental illness. *Prevention in Human Services, 11,* 315–331

Klien, A. R., Cnaan, R. A., & Whitecraft, J. (1998). Significance of peer social support with dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice, 8*(5), 529–551

Kurzman, P.A. (1990). The new careers movement and social change. *Social Casework*, 51, 22–27

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

Manning, S. S., & Suire, B. (1996). Consumers as employees in mental health: Bridges and roadblocks. *Psychiatric Services, 47*(9), 939–943

Markowitz, F. E. (2001) Modeling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-concept. *Journal of Health and Social Behavior, 42*(1), 64–79

Miles, M. B. & Huberman, A. M. (1994). Qualitative data analysis (2nd. Ed.). Thousand Oaks, CA: Sage

Miya, K., Wilbur, S., Crocker, B., & Compton, F. (1997). Addressing and resolving role issues between professionals and consumer employees. In C. T. Mowbray, D. P. Moxley, C. A. Japser, & L. L. Howell (Eds.), Consumers as providers in psychiatric rehabilitation (pp.334–346). Columbia, MD: International Association of Psychosocial Rehabilitation Services

Mowbray, C. T. (1997). Benefits and issues created by consumer role innovation in psychiatric rehabilitation. In C. T. Mowbray, D. P. Moxley, C. A. Japser, & L. L. Howell (Eds.), Consumers as providers in psychiatric rehabilitation (pp. 45–63). Columbia, MD: International Association of Psychosocial Rehabilitation Services

Mowbray, C. T., Moxley, D. P, Thrasher, S. P., Bybee, D., McCrohan, N., Harris, S. & Clover, G. (1996). Consumers as community support providers: Issues created by role innovation. *Community Mental Health Journal, 32*(1), 47–67

New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. (2003). Executive Summary, DHHS, Pub. No. SMA-03–3831. Rockville MD

Paulson, R., Herinckx, H. Demmler, J., Clarke, G., Cutler, G. & Birecree, E., (1999). Comparing practice patterns of consumer and non-consumer mental health service providers. *Community Mental Health Journal, 35*(3), 251–269

Pearl, A. (1974). Paraprofessionals and social change. *Personnel and Guidance Journal, 53*, 264–270

Pickett, A. L. (1984) The paraprofessional movement: An update. *Social Policy, 14*(3), 40– 43

Ralph, R. O. (2000). Review of recovery literature: A synthesis of a sample of recovery literature 2000. National Technical Assistance Center for State Mental Health Planning, National Association for State Mental Health Program Directors

Rothman, J., & Thomas, E. J. (Eds.), (1994). *Intervention research design and development for human service* New York: Haworth

Rothman J. & Tumblin, A. (1994). Pilot testing and early development of a model of case management intervention. In J. Rothman & E.J. Thomas (Eds.), *Intervention research design and development for human service* (pp. 215–244). New York: Haworth

Sarason, B. R., Sarason, I. G., & Pierce, G. R. (Eds.) (1990). *Social support: An interactional view* NY: Wiley

Salzer, M. S. (1997). Consumer empowerment in mental health organizations. *Administration and Policy in Mental Health, 24*(5), 425–434

Salzer, M. S. (2002). Best practice guidelines for consumer-delivered services. Peoria, IL and Bloomington, IL: Behavioral Health Recovery Management Project, An Initiative of Fahette Companies; Chestnut Health Systems and the University of Chicago Center for Psychiatric Rehabilitation

Salzer, M. S., & Shear, S. L. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal, 25*(3), 281–288

Schiff, A. C. (2004). Recovery and mental illness: Analysis and personal reflections. *Psychiatric Rehabilitation Journal, 27*(3), 212–218

Simpson, E. L., & House, A. O. (2005). Involving users in the delivery and evaluation of mental health services: systematic review. *BMJ, 325*, 1265–1268

Solomon, P. (2004). Peer support/ peer provided services underlying processes, benefits, and critical ingredients.*Psychiatric Rehabilitation Journal, 27*(4), 392–402

Solomon, P., & Draine, J. (1995). The efficacy of a consumer case management team: 2-year outcomes of a randomized trail. *The Journal of Mental Health Administration, 22*(2), 135–146

Solomon, M. L., Jonikas, J. A., Cook, J. A. & Kerouac, J. (1998). *Positive partnerships: How consumers and nonconsumers can work together as service providers. Second edition* Chicago, IL: National Research and Training Center on Psychiatric Disability

Steele, K., & Berman, C. (2001). *The day the voices stopped: A memoir of madness and hope* Basic Books: New York

Strauss , A. & Corbin, J. (1990). *Basics of Qualitative Research* Newbury Park: Sage

Torrey, W. C., & Wiyzik, P. (2000). The recovery vision as a service improvement guide for community mental health center providers. *Community Mental Health Journal, 36*(2), 209–216

Torrey, W, C., Rapp, C. A., Van Tosh, L, McNabb, C. R. A., & Ralph, R. O. (2005). Recovery principles and evidence-based practice: Essential ingredients of service improvement. *Community Mental Health Journal, 41*(1), 91–100

Vandergang, A. J. (1996). Consumer/survivor participation in the operation of community metal health agencies and programs in metro Toronto: Input or impact? *Canadian Journal of Community Mental Health, 15*(2), 153–170

Zwerling, C., Whitten, P. S., Davis, C. S., & Sprince, N. L. (1997). Occupational injuries among workers with disabilities: The national health interview survey, 1985–1994. *JAMA, 278*(24), 2163–2167